Frimley Health NHS
NHS Foundation Trust

In Partnership with the Ministry of Defence

Strategy

RISK MANAGEMENT STRATEGY 2015 - 2018

Key Points

- To set out the principles and framework for the management of risk at Frimley Health NHS Foundation Trust
- To set out clearly defined roles and responsibilities for the management of risk at all levels of the organisation

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Version Control

Version	Date	Policy Lead(s)	Status	Comment
0.1	Aug 15	Governance Manager	Draft	Policy drafted
0.2	Sept 15	Governance Manager	Final	Minor changes
0.3	Apr 17	Governance Manager	Final	Minor amendments to reflect changes made to the organisational wide governance structure and guidance for directorate clinical governance committees/groups

Document Location

Document Type	**Location**
Electronic	Policy Hub (Trust-wide)
Paper	
Paper	

Related Documents

Document Type	**Document Name**
	Policy for the Management including the Management of Serious Incidents
	Risk Assessment Guidelines
	Root Cause Analysis Guidance
	Duty of Candour Guidelines
	Being Open Policy
	Raising Concerns Policy

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Risk Management Strategy 2015 - 2018

1.0 Introduction

1.1 Frimley Health NHS Foundation Trust was established in October 2014, through the acquisition of Heatherwood & Wexham Park Hospitals NHS Foundation Trust by Frimley Park Hospital NHS Foundation Trust. The purpose of the acquisition was to enhance the quality of services for the local population and as an opportunity to help secure Frimley Park Hospital's sustainability. Additionally at the time of acquisition, Heatherwood & Wexham Park Hospitals were not financially sustainable and required considerable investment as part of the acquisition and stabilisation process. It had also been placed in 'special measures' over concerns raised by the CQC on the quality of care.

As part of the acquisition, the Trust reviewed the Governance Framework to ensure it was fit for purpose in the enlarged organisation. Frimley Park Hospital was well-recognised for having an established, effective, robust management and governance framework; with this in mind the new Trust has implemented the existing governance arrangements at Frimley Park Hospital, replacing the committee structures at Heatherwood & Wexham Park Hospital at acquisition, with some changes to ensure effective cross-site governance.

1.2 The aim of Frimley Health NHS Foundation Trust is to provide safe health services of the highest possible standard to our patients by:

- Employing best practice in clinical care and Infection Control
- Ensuring the patient safety is paramount
- Ensuring all patients are treated with privacy and dignity
- Ensuring that resources are used effectively
- Supporting all staff to realise their full potential

1.3 The management of risk is key in providing a safe service. All staff have a responsibility for identifying and minimising inherent risks. This will be achieved within a progressive, honest and open environment where mistakes and untoward incidents are identified quickly and acted upon in a positive way.

1.4 Frimley Health NHS Foundation Trust is dedicated to establishing an organisational philosophy that ensures risk management is an integral part of corporate objectives, business plans and management systems. Compliance with legislative requirements is only a minimum standard. The specific function of risk management is to identify and manage risks that threaten the ability of the Trust to meet its objectives.

The Board of Directors, Managers and staff will establish, maintain and support this holistic risk management programme and ensure that effective mechanisms are instituted for assessing and appropriately responding to findings. The following ten

key principles are essential for the successful implementation of the Trust's Risk Management Strategy:

- To demonstrate Board and Management commitment to risk management.
- To continuously review the effectiveness of the Trust Governance and Quality framework, to ensure it remains effective in the application of risk management process to clinical practices.
- To develop employee participation, consultation and accountability in risk management processes.
- To ensure a mechanism is in place for all incidents to be immediately reported, categorised by their potential impact and consequences and investigated to determine system failures in an open and fair manner.
- To ensure that systems are designed to reduce the likelihood of human error occurring.
- To ensure that formal mechanisms are in place to measure the effectiveness of risk management strategies & infection control strategies, plans and processes against NHS standards.
- To develop preventative risk management processes to be applied to the management of facilities, amenities and equipment.
- To ensure that Risk Management processes are applied to contract management especially when acquiring, expanding or outsourcing services so that only reasonable risks are accepted and that these risks are transferred to an insurance underwriter.
- To ensure that safe systems of work and practice are in place for the protection and safety of patients, visitors and staff.
- To ensure that the Trust has plans in place for emergency preparedness, emergency response, business continuity and contingency.

2.0 Purpose & Scope

2.1 The purpose of the Governance & Risk Management Strategy document is to describe clearly the structure and strategy for the future development of Governance & Risk Management within the Trust over the next three years. It will define the Risk Management roles and responsibilities of staff within the Trust and the reporting relationships between the key Committees with responsibility for the Management of Risk. It also sets out the risk management priorities and objectives for the Trust and future actions needed for the implementation of this Strategy.

2.2 This Strategy is applicable to all members of staff within the organisation, both temporary and substantive. The Strategy is also applicable to all staff contracted to provide services to the Trust including honorary contract holders and to all workers of other organisations visiting the Trust sites in the course of their employment or studies.

3.0 Definitions

Hazard: A hazard is something that can cause adverse effects (e.g. an object, a property of a substance, a phenomenon or an activity)

Consequence: The measure of the effect of the hazard is defined as the 'consequence'

Likelihood: Likelihood is that chance an event will occur

Risk: A risk is the likelihood that a hazard will actually cause its adverse effect together with a measure of the effect (consequence). Risk assessments are undertaken using a consequence x likelihood calculation (See Appendix A)

Control is the mitigating action put in place to reduce the risk

4.0 THE STRATEGY

The Trust believes that risk management is one of the essential elements of governance, and it is a major focus for changing and improving both clinical and non-clinical practices within the NHS. Well-developed risk management and effective incident reporting processes as identified by the Department of Health are essential. The Trust acknowledges the importance of gathering risk information and data to ensure that lessons are really learned from incidents, and that appropriate actions are taken and implemented throughout the organisation to ensure that there will be minimal risk of similar incidents occurring elsewhere within the Trust.

Prevention and control of risks is a key objective and a high priority for the Trust. The Board of Directors commitment to the development of the Risk Management Strategy is derived from the fundamental aim and objective of providing the best possible care and treatment for all patients within a safe environment.

The Trust actively reviews and embraces the recommendations from National Investigations, Inspection and reviews such as:

- Lord Darzi's review *High Quality Care for All*, *June 2008* which describes patient safety, clinical outcomes and effectiveness and patient experience as being fundamental to effective governance
- The Francis Report & Recommendations (February 2013) following an extensive inquiry into Mid-Staffordshire NHS Foundation Trust,
- The Morecombe Bay Investigation Report (March 2015) following an independent investigation into the management, delivery and outcomes of care provided by the maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust
- The Keogh Report (July 2013) following a review into the care and treatment provided by a number of Trusts with persistently high mortality rates.

- Southern Health Report December 2015 following a review into deaths of people with a learning disability or mental health problems commissioned by NHS England in July 2013

The Trust has also considered a range of other national guidance including:

- *National Guidance on Learning From Deaths , a Framework for NHS Trusts & NHS Foundation Trusts on Identifying, Reporting, Investigation & Learning from Deaths in Care, March 2017*
- 'Improving the Safety of Patients in England' *Berwick Review of Patient Safety in England August 2013*
- 'Review of Early Warning Systems in the NHS' *National Quality Board February 2010*

4.1 LEVEL OF RISK

The key challenge in terms of risk, over the next 3 years, is the delivery of the cost improvement programme and the re-organisation of the commissioner landscape. This will mean that more integrated care services will be delivered in the community resulting in static or reduced hospital activity.

To manage this risk, the Trust has established a Project Management Office to support internal and external transformation. The aim will be to redesign service delivery to improve efficiency, costs, clinical outcomes and patient experience. The transformation and cost improvement programmes will collectively deliver £32m in 2017/2018.

A full Quality Impact Assessment will be undertaken and signed off by the Director of Nursing and Medical Director to ensure there is no impact on quality, safety or patient experience. This will be monitored by the Board of Directors.

4.2 THE PROCESS OF RISK MANAGEMENT

Risk can be defined as the probability of incurring harm, adverse incidents or outcomes. The definition applies equally to all types of risk including clinical, health & safety, business and reputation risk. E.g. Clinical risk is a potential undesirable accident in which a patient is unintentionally harmed by treatment or care in a healthcare environment

There are two key ways of applying the Risk Management Process:

- In the **first** instance, a pro-active process of identifying risks and taking preventative measures **before** an incident happens i.e. **Risk Assessment.** Grading risks, documenting current control measures and identifying future action plans for reducing risk.

- In the **second** instance, to learn lessons **after** an incident, complaint or claim i.e. **Incident Reporting Procedures,** taking steps to minimise the damage and to make changes in practice to prevent any future repetition of the incident

4.3 Identification of Risks

4.3.1. Risk Assessment

The formal proactive method of identifying operational risks within the Trust is through the use of risk assessments. Clinical, non-clinical and business planning risk assessment is well established within the Trust. These risks then populate the directorate/specialist risk assurance frameworks. The Board of Directors are responsible for identifying strategic risks associated with strategic direction of the organisation.

The Trust is committed to ensuring that integrated clinical and non-clinical risk assessments in all departments are regularly updated and formally reviewed on an annual basis. All types of risk identified are graded using a common grading matrix (See Appendix A) which measures the risks in terms of both consequence and likelihood. (Refer to Trust Guidelines for conducting a Risk Assessment). Risks graded moderate, high & extremely high from a corporate perspective will be entered onto the Trust Risk Assurance Framework allowing meaningful comparison of risk priorities for the organisation and will be reported to the Board of Directors.

4.3.2. Incident Reporting

The formal reactive method of identifying risks within the Trust is through the incident reporting procedure (Policy for the Management of Incidents Including the Management of Serious Incidents). Incident reporting is well established throughout the organisation with all groups of staff embracing the concept and benefits of reporting.

The Trust is committed to developing the reporting culture throughout all professional groups of staff and achieves this by ensuring that action is taken, changes in practice are implemented and services are improved as a direct result of the review and investigation of incidents, and by identifying and reacting to trends.

All incident reports are entered onto the Datix Risk Management information system and are categorised for type and severity. Generic categories of risk reporting have been agreed for the whole of the Trust, including specific clinical triggers which have been developed by the Clinical Directorates. The Deputy Director of Nursing & Risk ensures reporting of trends using these categories on a quarterly basis.

The Trust is committed to the future development of the Datix system and will be supporting the integration of the two separate systems into one system to allow meaningful comparison of data across the enlarged organisation. The Patient Safety teams assess and review the grading, level of harm and severity of each incident.

Department/Ward Managers assess the incident report forms and categorise and grade each one before submitting it electronically to the Patient Safety team for final approval. This approach ensures that the manager is aware at an early stage of any evolving trends and increases the ownership and credibility of the risk data. It also ensures that higher risk incidents are clearly identified to the manager who can initiate immediate action as required. (See Policy for the Management of Incidents Including the Management of Serious Incidents)

4.3.3 Acceptable Risk

The Trust is committed to making every effort to ensure that all risks are identified and managed appropriately to ensure they are as low as reasonably achievable.

It is not possible to completely eliminate risk. However, all identified risks will be analysed with regard to likelihood and consequence and possible control measures will be documented using the Risk Assessment Form. The Board of Directors is responsible for making financial and management decisions to ensure that where possible, risks are effectively controlled and minimised to ensure the best use of resources and balance of risks based upon the key priorities and objectives of the Organisation. The Trust defines 'risk' as follows:

***Acceptable Risk**: Where a risk is assessed, using the Trust Grading Matrix and the control measures are considered to be adequate to manage the risk safely.*

***Unacceptable Risk**: Where a risk is assessed as 'extremely high', 'high' or 'moderate', using the Trust Grading Matrix and the control measures are not considered to be adequate to manage the risk safely, the Executive Team are actively involved in developing solutions to reduce the risk to a manageable level*

Risks may be accepted by the organisation because the cost of the risk treatment or control is so excessive compared to the benefit. This applies particularly to lower graded risks. A business corporate opportunity may outweigh any potential threat to such a degree that the risk is justified. Calculated risks should be taken to enable the Trust to benefit from opportunities to optimise the performance of the organisation. The Board of Directors is responsible for considering the balance of risks and making an informed decision.

In clinical terms, the balance of known risks in relation to the potential benefit of treatment or operation must be presented to the patient to ensure they are able to give informed consent.

4.4 Corporate Risk Assurance Framework

The Trust Corporate Risk Assurance Framework provides a Trust wide database of all extremely high, high and moderately graded risks to the Trust. The Framework is populated based on the following key areas:

- The Strategic Goals, Trust Quality Strategy & Performance Plan identifying key corporate and directorate objectives
- Business Planning Process
- The Clinical Governance Committee & Trust Annual Integrated Clinical & Non Clinical Risk Assessment
- Adhoc speciality/directorate risks assessment
- Speciality/directorate level risk assurance frameworks
- Ongoing risks identified from incident reporting
- Outcome of external assessment and/or inspection

The Framework has been developed to provide an overarching analysis for all types of risk providing information about the current control measures and assurances in place, and action plans for reducing risks and identifies the following:

- Source of the risk
- Description
- Risk Grade
- Controls in Place
- Actions
- Residual Risk Rating
- Date of Review

The Framework is a dynamic document which is constantly changing as actions are taken addressing high risk issues for the organisation. New risks are added as they are identified, from specific internal incidents, national external reviews, local Risk Registers and as part of the annual review of Risk Assessments. The Deputy Director of Nursing & Risk is accountable for the Corporate Risk Register and data is co-ordinated by the Governance Manager.

The Corporate Risk Assurance Framework is fully reviewed every month at the Corporate Governance Group and a the key changes and risk ranking is reviewed by the Board of Directors every month.

4.5 Management of Risk Locally

Associate Directors/Heads of Service/Chiefs of Service are responsible for ensuring that the principles of the Trust Risk Management Strategy are implemented locally in each department/directorate and monitoring compliance with the following key objectives:

- To evidence incident reporting from all staff within the department/directorate and formal review of incidents, complaints and claims by the Managers following the principles of Root Cause Analysis where required.
- To undertake an annual directorate clinical and non clinical risk assessment
- To maintain local level Risk Assurance Frameworks populated from local incident reporting, risk assessments, and national targets which will be monitored by the

executive team on a monthly basis at the Corporate Governance Group and key risks are considered at the 6-monthly directorate reviews

- To present an annual directorate report to the Clinical Governance Committee which will include a declaration of local level compliance against the Care Quality Commission Outcomes of Quality & Safety and subsequent Care Quality Commission Registration requirements relevant to the area i.e. mandatory training, incident reporting, patient experience, NICE Guidance etc.

4.5.1 Local level Risk Assurance Frameworks

Local level risk assurance frameworks are managed and reviewed by the Directorates/Speciality, Chiefs of Service and Associate Directors/Heads of Service. It is the responsibility of the Associate Director/Head of Service to submit the local risk assurance frameworks to the Corporate Governance Group on a monthly basis to be formally monitored by the Executive Team.

In a local risk assurance framework, the Associate Directors/Heads of Service will be required to identify:

- the description
- the level of risk
- controls in place
- agreed actions to be taken
- progress to date
- the residual risk rating

Identified risks will initially be graded for their impact at a Directorate/Speciality level using the Trust's Grading Matrix (Appendix A) with further guidance available at Appendix B

Any risks grading 'high' or 'extremely high' at a Directorate level are reported to the Trust Corporate Governance Group for discussion by the Executive team and where appropriate, addition to the Corporate Risk Assurance Framework.

4.6 Levels of Authority for the Management of Identified Risks

The level at which the risk will be managed in the organisation and priorities assigned for corrective action will be on the basis of the risk rating and colour bandings identified (see Table 4). Heads of Department/Nursing will consider and lead the review of moderate level incidents also following the principles of Root Cause Analysis.

Risk Colour	Remedial Action	Decision to accept risk	Risk Register level
Green Low	Ward Sister/Charge Nurse/ Head of Department	Ward Sister/Charge Nurse/ Head of Department	Clinical Speciality
Orange Moderate	Associate Director Head of Service Head of Nursing/Clinical Matron	Chief of Service or Exec Director Corporate Governance Group	Trust Wide
Red High	Associate Director Head of Service Director	Executive Team	Trust Wide
Purple Extremely High	Director	Executive Team	Trust Wide

4.7 Root Cause Analysis

Formal Root Cause Analysis is well established, a Trust framework, and a structured approach for the process of analysis is in place of for the review of incidents, complaints and claims.

By adopting formal root cause analysis to clearly identify the causes and contributing factors of incidents, the Trust ensures action is taken to prevent the potential for reoccurrence both locally and corporately. (See Root Cause Analysis guidance)

The Trust has developed and implemented a systematic root cause analysis process specifically for infection related incidents.

4.8 Being Open & Duty of Candour

Effective communication with patients begins at the start of their care and should continue throughout their time with the Trust and this should be no different when a patient safety incident occurs. Openness about what has happened and discussing incidents promptly, fully and compassionately can help patients cope better with the after effects. Saying sorry is not an admission of liability and patients have a right to expect openness in their healthcare.

In line with the guidance from the National Patient Safety Agency and NHS Commissioning Board, the Trust has developed Guidelines for Being Open when a patient is harmed as a result of a patient safety incident. (See Guidelines for Being Open) The Trust has also taken on board the recommendations from the Francis Report and has done further work to ensure the Trust compliant with the law in relation to Duty of Candour (see Guidelines for Duty of Candour).

4.9 Supporting Staff

The Trust recognises that staff can often feel vulnerable when involved in serious incident investigations, Coroner's Inquests, police investigations or the litigation process. Experience of past cases has demonstrated that it is particularly important that individuals are appropriately supported during and after the case. Individuals, regardless of grade or position, may feel anxious about their involvement and their future role in the progress of the case. The Trust is committed to providing appropriate support package for the individuals concerned. (see Supporting Staff Guidelines)

5.0 KEY ROLES & RESPONSIBILITIES

5.1 Chief Executive

The Chief Executive has overall responsibility for Risk Management throughout the Trust. However, the Director of Nursing is the nominated lead for the strategic development of Risk Management, and for ensuring that risk management is part of everyday practice throughout the Trust. The Director of Finance has delegated responsibility for Financial Risk Management and for ensuring the financial stability of the Trust.

The overall risk management programme will be coordinated by the Trust Corporate Governance Group which is chaired by the Chief Executive. This group ensures that the strategic direction for risk management is appropriate and supported by the implementation of this strategy, providing regular reports to the Board of Directors.

5.2 The Board of Directors

Board of Directors (both Executives and Non-Executives are individually and collectively responsible for ensuring that there is a strong Risk Management approach to all aspects of the Trust's activities. Business priorities and decisions made by the Board of Directors must reflect Risk Management assessments and consideration of high risk factors and be in line with the Trust's Quality Strategy.

5.2.1 Executive Directors

All Executive Directors and Chiefs of Service of the Trust, both individually and as members of the Hospital Executive Board, have a key role to play in developing this approach and in ensuring that the Board of Directors is supported to carry out this role.

5.2.1.1 Director of Nursing, Quality & Patient Services

The Director of Nursing is the executive lead with responsibility for managing the strategic development and implementation of the Trust's Quality Strategy and Trust's Corporate Assurance Framework and is accountable for ensuring there is a robust system in place for monitoring compliance with the Care Quality Commission Outcomes of Quality & Safety. The Director of Nursing is responsible for managing quality, patient safety, complaints, and medical negligence claims and setting the quality standards.

5.2.1.2 Medical Director

The Medical Director is responsible for the Trust's Quality Strategy and Clinical Governance within the Trust in conjunction with the Director of Nursing, ensuring effective integrated quality governance is developed and monitored.

5.2.1.3 Director of Human Resources & Corporate Services

The Director of Human Resources and Corporate Services has overall responsibility for workforce planning, ensuring the right staff are in the right jobs, and for the management of the Occupational Health and Safety Department. The Director of Human Resources and Corporate Services ensures that the estate is developed to support Trust strategic direction and that the condition of the estate is maintained and is fit for purpose and that hotel services are effective and efficient. The Director of Human Resources and Corporate Services is the co-executive lead for the local implementation of the Climate Change Act 2008 and the development and implementation of the Trust's Carbon Reduction Strategy. The Director of Human Resources and Corporate Services develops the Trust's public and staff engagement strategy.

5.2.1.4 Directors of Operations

The Trust has two Directors of Operations, one based at Frimley Park Hospital (FPH) and one at Wexham Park Hospital (WPH). They are responsible for the day-to-day management of the Trust. The role co-ordinates plans and strategies to ensure that the organisation develops services in an efficient and economical manner in response to the changing economic climate. The roles involve ensuring that the Trust meets national and local performance objectives.

The Director of Operations for FPH is the lead for delivering the Innovation & Change programmes which transform services within the Trust and Health Economy. The Director of Operations for WPH is the lead for Emergency Planning and Business Continuity across the Trust.

5.2.1.4 Director of Finance

The Director of Finance (FD) oversees the adoption and operation of the Trust's Standing Financial Instructions including the rules relating to budgetary control, procurement, banking, staff appointments, losses and controls over income and expenditure transactions and is the lead for Counter Fraud. As the lead director for IM&T, is responsible for the security of patient records and IT disaster recovery arrangements.

5.2.1.5 Senior Information Risk Owner (SIRO)

As the Trust Senior Information Risk Owner (SIRO), the Director of Finance is responsible for ensuring that the Trust creates and manages its information risks, through the development of a network of Information Asset Owners (IAA's) and Information Assess Administrators (IAAs).

The FD attends the Trust Audit Committee but is not a member, and liaises with Internal and External Audit who undertake programmes of audit with a risk based approach.

5.2.2 Non-Executive Directors

The Board's Audit Committee is chaired by a nominated non-executive director (NED) and has 2 other NEDs as its members. All NEDs have a responsibility to robustly challenge the effective management of risk and to seek reasonable assurance of adequate control. In order to assure the Board that clinical risk is properly identified and managed, all to take part in the programme of Quality Assurance Walkabout. At least one NED also attends meetings of the Clinical Governance Committee and the Patient Experience Forum.

5.3 Council of Governors

The role of the Council of Governors role is to hold the Board of Directors to account, through the NEDs, for its performance in leading the organisation and, in particular, in ensuring that the needs and views of Members of the Trust, the wider public, and key stakeholders are represented in the Trust's strategy and direction. To assist the Council of Governors in carrying out this role, Governors meet regularly with the Board of Directors to review performance and discuss service improvements. In addition, Governors have their own Patient Experience & Involvement Group which works with the Director of Nursing, Quality & Patient Services to bring about improvements in patient experience. Governors also take part on a rolling basis in Quality Assurance Walkabouts and nominated Governors are members of the Clinical Governance Committee.

5.4 Deputy Directors of Nursing

Deputy Director of Nursing, Quality & Risk (FPH)

The role and responsibilities of the Deputy Director of Nursing, Quality & Risk is to promote risk management activity awareness and training throughout the Trust. The post holder is directly accountable to the Director of Nursing, with a key function of

providing central support and advice to the Board of Directors regarding the establishment of an effective system of internal control and developing the Corporate Assurance Framework.

The Deputy Director of Nursing, Quality & Risk has an overarching responsibility for ensuring there is an effective incident reporting process and effective management of all risk data and information, producing the Trust Risk Register and providing reports and trend analysis information to support the prioritisation of risk.

The Deputy Director of Nursing, Quality & Risk will ensure that all serious risk incidents are reported to the Foundation Trust Monitor, Clinical Commissioning Groups and NHS England and managed in line with the Policy for the Management including the Management of Serious Incidents

The Deputy Director of Nursing, Quality & Risk is responsible for providing leadership to support the implementation of the Trust's Quality Strategy, the Sign up to Safety Campaign and ensuring the annual Quality Report is compliant with Foundation Trust Monitor guidance.

Deputy Director of Nursing Patient Involvement & Engagement (WPH)
The Deputy Director of Nursing, Patient Involvement & Engagement is accountable for developing and implementing the Trust Patient Experience & Engagement Strategy. Ensuring the Trust is compliant with the NHS Complaints Procedure, responsive to patient feedback and maximising opportunities to improve patient experience. The Deputy Director of Nursing, Patient Involvement & Engagement will ensure the Trust monitors Friends & Family response rates and feedback identifying themes and leading changes in practice to improve the quality of care and services. The post holder will lead the development of a Trust Volunteers Strategy and the Trust Patient Involvement & Engagement Group working with Governors and members of the public.

5.5 Head of Patient Safety

The Head of Patient Safety reports to the Deputy Director of Nursing, Quality & Risk (FPH) and is responsible for developing high standards of clinical risk management throughout the Trust. The Head of Patient Safety monitor patient safety incident reporting, and works with clinicians and Directorate level Clinical Governance Committees on specific clinical risk issues. The Head of Patient Safety also works closely with the Medical Director, Director of Nursing and Head of Midwifery regarding all high-risk clinical incidents. The Head of Patient Safety is supported by a Deputy Head of Patient Safety on the Wexham Park Hospital site.

The Head of Patient Safety (FPH) is responsible for co-ordinating the Sign up to Safety and Leading Improvement in Patient Safety programmes.

The Head of Patient Safety has a significant role in developing and reviewing clinical policies and procedures of the Trust and in the education of all medical clinical and nursing staff regarding risk management awareness. The Head of Patient Safety (FPH)

is responsible for developing the risk training needs analysis and monitoring its' effectiveness.

The Health Safety and Environment Committee are responsible for addressing health and safety issues, the Head of Patient Safety is also a member of this committee.

5.6 Deputy Medical Directors

The Trust has two Deputy Medical Directors who play a leading role in driving improvements in patient safety, chairing complex Serious Incident panels, reviewing mortality and CRAB data and engaging consultants in the patient safety agenda. The Trust also has three consultant patient safety champions who support the patient safety programme.

5.7 Heads of Quality

The Heads of Quality report to the Deputy Director of Nursing, Quality & Risk (FPH) and are responsible for developing and continuously improving Quality Assurance and monitoring the Trust against the national quality standards. The post holders have a significant role in commissioning and contracting to ensure quality and patient experience issues are central to the development of care pathways and monitoring performance targets against the Trust's Quality Strategy and Quality Account. They are also accountable for negotiating and delivering the annual national and local CQUIN targets.

5.8 Head of Patient Experience

The Head of Patient Experience report to the Deputy Director of Nursing & Patient Involvement & Engagement (HWP) and is responsible for managing the Complaints process, monitoring the Friends & Family results and coordinating Quality Assurance Walkabouts. The post holder is responsible for liaising and engaging with external stakeholders including Healthwatch.

5.9 Head of Midwifery

The Head of Midwifery encompasses the role of Risk Manager within Maternity and is responsible for managing and co-ordinating the risk obstetric management strategy and Clinical Governance Strategy of the Maternity Department. The post holder has a specific role in developing and reviewing clinical policies and procedures in midwifery and in the education of clinical staff regarding risk management issues.

The Head of Midwifery ensures effective liaison and reporting between the Trust's Head of Patient Safety and the Patient Safety Department. She is also a member of the Patient Safety Committee.

5.10 Governance Manager

The Governance Manager is directly responsible to the Deputy Director of Nursing & Risk for the day to day management and maintenance of the Trust Risk Assurance Framework and for supporting directorates with implementing local risk assurance frameworks. The post holder has a specific role as the Manager for the Datix Risk

Management information system and the management of the corporate information to support compliance with the Care Quality Commission Registration Standards.

5.11 Head of Occupational, Health & Safety

The Head of Occupational, Health & Safety is responsible for ensuring high standards of Health & Safety throughout the Trust and for monitoring all non-clinical incidents. The post holder has a significant role in the training and education of staff and ensures the Trust's compliance with the Health and Safety Executive legislation and regulations. Duties and responsibilities of all employees are stated in the Health & Safety Policy.

5.12 Head of Information Governance

The Head of Information Governance is responsible for ensuring that the Trust has a robust Strategy of policies and procedures for the management of the Trust's information, both corporate and clinical/patient. The Head of Information Governance liaises with the Trust's Caldicott Guardian and Senior Information Risk Owner to ensure that the Trust meets and complies with the standards set out in the Information Governance Toolkit.

5.13 Chiefs of Service/Associate Directors

Senior Managers and Managers at all levels of the organisation have a responsibility where ever possible to manage risks at a local level in their respective wards and departments, and to develop an environment where staff are encouraged to identify and report risk issues proactively. All managers are expected to ensure that their staff report any near miss incidents, adverse incidents and serious incidents immediately using the Trust incident reporting procedure.

Chiefs of Service/Associate Directors are responsible for developing local quality indicators to include clinical outcomes, patient safety and patient experience issues. They are also responsible for ensuring emergency planning is understood locally and business continuity plans are developed in line with the Trust framework.

Managers are also responsible for ensuring that staff receive appropriate feedback regarding specific incidents reported, and for ensuring that any recommendations following investigation of an incident are implemented where appropriate audited at a later date to ensure they have been effective in reducing the likelihood of the incident happening again.

5.14 All Staff

All members of staff have an important role to play in identifying and minimising risks and hazards as part of their everyday work within the Trust. Each individual has a responsibility for their own personal safety and for the safety of their colleagues, patients and all visitors to the Trust.

All staff are expected to have an understanding of the Incident Reporting Procedure, and knowledge of the types of incident, which must be reported. They must also have

knowledge of specific directorate level incident triggers relevant to their department, which also require reporting.

6.0 CORPORATE GOVERNANCE COMMITTEE STRUCTURE (see appendix C)

6.1 Board of Directors

The Board of Directors attaches great importance on ensuring that the Trust operates to high ethical and compliance standards. In addition it seeks to observe the principles set out in the Monitor NHS Foundation Trust code of Governance.

The Board is responsible for the management of the Trust and for ensuring proper standards of corporate governance are maintained. The Board accounts for the performance of the hospital and consults on its future strategy with its members through the Council of Governors.

The Board of Directors receives exception reports against performance standards and these have been introduced to assist the Board in identifying areas of high risk. Significant high graded risks facing the organisation are monitored and added to the Trust Corporate Risk Assurance Framework.

The Board of Directors is responsible for:

- Monitoring progress against the Trust objectives, both strategic and operational
- Identifying the significant risks that may threaten the achievement of the Trust objectives
- Maintaining dynamic risk management arrangements including, crucially, a well founded Risk Register & Corporate Assurance Framework, reviewed quarterly by the full Board of Directors.

It is crucial that the Board knows what the key risks are and are satisfied that they are being properly managed

6.2 High Level Risk Committees

Responsibility for specific risk management areas has been delegated to the following high risk committees each of which has approved Terms of Reference and Membership:-

6.2.1 Financial Assurance Committee

Providing an objective view of the financial performance, and financial strategy of the Trust, together with an understanding of the risks and assumptions within the Trust financial plans and projections.

6.2.2 Audit Committee & Internal Audit

The Committee reviews the establishment and maintenance of an effective system of audit, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy of:

- The processes supporting all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission Outcomes of Quality & Safety), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service

6.2.3 Corporate Governance Group

- To assess, prioritise and monitor the Trust performance in managing risk and ensuring progressive improvement against the Trust 'live' Corporate Risk Assurance Framework and local directorate risk assurance frameworks
- To prioritise the top risks to inform the Audit Committee and to be reviewed by the Board of Directors
- To ensure the Trust has an Risk Assurance Framework that is robust and fit for purpose, and complies with best practice
- To review the Risk Assurance Framework identifying any gaps in assurance to inform the Audit Committee and to be reviewed by the Board of Directors
- To compile, in conjunction with the Chief Executive, the Annual Governance Statement which will be passed to the Audit Committee to review its adequacy
- To advise the Trust in respect of the development and use of key performance and risk indicators
- To sign off compliance with the current Care Quality Commission standards of quality and safety and subsequent registration requirements.
- To initiate systematic reviews of practice in the light of external reports and act upon key recommendations
- To support the Audit Committee to undertake risk based work programmes where gaps in assurance are identified. Responding to findings of the Audit Committee ensuring action is taken

6.2.4 Commercial Development and Investment Committee (CDIC)

- To ensure that major capital investment schemes are in lines with the Trust's overall agreed strategy
- To offer the Board of Directors assurance on the rigour of the Transformation Plan
- To review key commercial arrangements including long term leases and major service developments and track progress of such developments as appropriate
- To review the financial aspects of the Trust's Annual Plan before its submission to the Board of Directors

6.2.5 Quality Assurance Committee

- Providing assurance that the risks associated with the Trust's provision of excellent care are identified, managed and mitigated appropriately. In doing so, the Quality Assurance Committee may take any that is sees fit to ensure that this can be achieved.
- Providing assurance to the Board by:
    - Ensuring that the strategic priorities for quality assurance are focused on those which best support delivery of the Trust priority objectives in relation to patient experience, the safety of patients and service users and effective outcomes for patients and service users;
    - Reviewing the independent annual clinical audit programme, ensuring it provides a suitable level of coverage for assurance purposes, and receiving reports as appropriate;
    - Reviewing compliance with regulatory standards, for example those of the CQC (confirm and challenge process), NHSLA, and Monitor (Quality Governance Framework);
    - Reviewing non-financial risks on the Risk Assurance Framework which has been assigned by the Trust to satisfy itself as to the adequacy of assurances on the operation of the key controls and the adequacy of action plans to address weaknesses in controls and assurances;
- Overseeing 'Deep Dive Reviews' of identified risks to quality identified by the Board
- The Committee may also initiate such reviews based on its own tracking and analysis of quality trends flagged up through the regular performance reporting to the Board.

6.2.6 Quality Committee

- To coordinate and implement all the responsive actions being taken by the organisation in relation to quality and provide monthly assurance to the Board that the quality agenda is being embedded in line with the Quality Strategy and that performance is measured and monitored
- To ensure the Trust is provided a high quality service
- To be responsive to significant patient safety risks
- To oversee, monitor and review the quality of services provided by the Trust
- To review internal core and speciality dashboards and external quality improvement targets:

- Clinical outcomes
- Patient Safety
- Patient Experience

- To identify key quality and patient safety risks from review of mortality data and undertake mortality and morbidity review at both speciality and Trust level
- To receive and review the findings from the Harm Event Monitoring GTT team and agree actions
- To ensure progress in implementing action plans to address shortcomings in the quality of services, should they be identified

6.2.7 Trust Morbidity & Mortality Review Group

- To bring together all those with an interest in improving practice around morbidity and mortality outcomes, to ensure multi-professional learning is disseminated across specialities and to monitor performance against these goals
- To ensure each speciality has robust processes in place for reviewing morbidity and mortality
- To oversee, monitor, review and report on the findings of speciality morbidity and mortality reviews, this will include:
  - The register of attendance
  - The number of cases reviewed and discussed
  - The areas of concern highlighted by each Speciality
  - Multi-professional, Trustwide these identified
  - Progress against agreed actions set by each Speciality including leads responsible and timescales for completion

6.2.8 Clinical Governance Committee

- To set, agree & review strategic direction for the Clinical Governance Framework and provide assurance to the Board of Directors via the Quality Assurance Committee
- To set & agree a Corporate Clinical Governance Action Plans and agree action programmes for sub committees
- To agree & monitor performance of individual directorate clinical governance objectives and action plans with particular reference to Quality of Care, Patient Safety, Infection Control, risks assessments/registers, compliance with the Care Quality Commission Outcomes of Quality & Safety
- To receive reports from the relevant sub committees and recommend actions
- To harmonise corporate & directorate clinical audit programmes and develop the role of the Clinical Audit and Effectiveness Committee to provide additional assurance to the Board of Directors

6.2.9 Directorate Clinical Governance Committees

- To review and monitor clinical governance and risk management arrangements within the Directorate.In particular, Directorate Committees are responsible for reviewing the following risk issues at least quarterly (see guidance at Appendix C):
  - Directorate incident reports, complaints & claims together with actions plans and lessons learnt

- Directorate Local Risk Assurance Framework
- Directorate Quality Dashboards
- Directorate clinical guidelines and patient information leaflets
- Directorate clinical audit plans
- Directorate compliance with mandatory training requirements
- Implementation of national legislation, national policies, evidence based practice (i.e. NICE Guidance, NCEPOD Reports etc)
- Directorate Health & Safety issues

6.3 Other Risk Management Related Committees

6.3.1 Hospital Executive Board

- To review financial, contractual and quality performance on a monthly basis
- To discuss and agree recommendations relating to policy and strategy
- To ensure that the hospital is patient-focused and has improving patient experience at the heart of all it does
- To receive advice from the Clinical Governance Committee, ensure that the hospital has sound clinical governance and risk management arrangements, complies with key quality standards and undertakes a quarterly review of the Corporate Risk Register

6.3.2 Nursing & Midwifery Forum

- To oversee, monitor, review and report on the performance of all nursing clinical wards and departments.
- To ensure effective action plans are developed by the Clinical Matrons and Head of Nursing quarterly to address areas of poor performance and deliver sustained improvement based upon national best practice.
- To ensure action is taken promptly in response to patient feedback with the aim of improving patient and public satisfaction throughout the Trust.
- To undertake benchmarking with other high performing Trusts and introduce innovative programmes to enhance Nursing Clinical Outcomes, Patient Safety and Patient Experience.
- To review Nursing/Midwifery SUI findings and act upon lessons learnt in all areas.
- To receive relevant National and Local monitoring reports regarding Clinical Outcomes, Patient Safety and Patient Experience as appropriate.

6.3.3 Patient Safety Committees

- To review significant clinical incidents, monitor trends, agree and monitor actions required, and initiates audit of changes in practice as a result
- To report on a quarterly, or one-off basis for issues of immediate concern, through the Trust Clinical Governance Committee to the Hospital Executive Board and Board of Directors

6.3.4 Patient Experience Forum

- Review and monitor patient experience feedback including surveys, NHS Choices, quality assurance walk-arounds and complaints, both informal and formal, to identify potential trends, themes, learning points and changes to practice
- Review and monitor themes and trends from GP and CCG complaints where these relate to patient experience.
- To monitor patient feedback processes continuously to improve the service user experience based on feedback to and from patients, carers and relatives.
- To receive reports on progress from National Surveys and to ensure that improvements points are being implemented and evidencing improvement in the service user experience.
- Ensure that systems and processes are in place to understand patient experience and complaints across every aspect of the Trust services
- Ensure that the Complaints policy is updated in line with local and national guidance

6.3.5 Occupational Health, Safety & Environment Committee

- To ensure that the Trust complies with Health and Safety Executive Legislation's
- To address Occupational, Health & Safety risk issues.
- To monitor non-clinical incidents

6.3.6 Information Governance Committee

- To report to the Trust Board through the SIRO on a quarterly basis. The SIRO is also responsible for keeping the Board of Directors informed of any issues of note on a monthly basis.
- To approve information governance action plans to meet central and local Information Governance requirements.
- To approve the Trust's Information Governance toolkit scores and submissions to Connecting for Health.
- To oversee the activities of staff in light of data protection, confidentiality, security, information quality, record management and Freedom of Information responsibilities.
- To ensure training needs are identified and training programmes are developed to facilitate successful implementation

6.3.7 Emergency Planning Steering Group

- To review and implement all Trust emergency plans to enable the hospital to respond to a major emergency (of whatever nature) whilst maintaining critical services.
- To agree and establish a training programme to deliver emergency training to relevant staff groups.
- To agree and establish an exercise programme to ensure the Trust is compliant with the Civil Contingencies Act
- To ensure that Business Continuity Plans are established, monitored and reviewed and a governance structure established.

- To ensure that contracts with suppliers and external organisations provide assurance regarding their business continuity planning and the sustainability of services provided to the Trust.

6.4 Reporting Structure

The corporate governance structure chart at Appendix C depicts the reporting relationships of these committees. They will communicate with each other and co-ordinate meetings to ensure timely consideration by the Governance Group of significant risk issues.

7.0 Risk Management Training & Education

Contributing to Risk Management is the responsibility of all members of staff, and the Trust recognises the importance of providing risk education and awareness training for all grades of clinical and non-clinical staff. A risk management training needs analysis is undertaken to ensure that training provided meets the needs of specific groups of staff. As a minimum, annual risk management training is mandatory for all clinical staff.

The following training and education will be provided to support the implementation of the governance & risk management strategy.

7.1 Board Members, Associate Directors & Heads of Service

The commitment and engagement of the senior management team within the organisation is paramount in creating a foundation for the implementation of the Strategy and imbedding the key principles throughout the Trust. To support this priority, regular updates and awareness training programmes will be provided on an on-going basis, at least annually, from both internal and external experts. For executive and non-executive directors, this will form part of the on-going Board Development programme.

The Corporate Risk Management Training Needs Analysis describes the key training requirements of all levels of staff including the Board Members and Senior Managers.

7.2 All Staff

- Risk management awareness and the incident reporting procedure as a structured part of the Trust's induction programme for new staff. This is also included in the induction programme for all medical staff
- Regular risk management updates for staff which can be linked to specific clinical risk or health and safety training programmes, including raising awareness of policies, i.e. Health & Safety Policy, Infection Control and Incident Reporting Procedure.
- Training for Line Managers in risk assessment & grading, root cause analysis, Supporting Staff and Being Open

- Training for Line Managers in the implementation of the Strategy and to support the devolvement of the Risk Management process to directorate and department levels
- All staff will be given risk awareness training upon commencement of their employment within the Trust, with regular updates thereafter.

7.3 Funding

Risk Management Plans form part of the Trusts business plans. Risk Management issues are funded at the budget setting process from bids submitted from each directorate following discussions during the six-monthly reviews. Where unforeseen risk management issues are identified, these are prioritised by the Corporate Governance Group and funding agreed by the Hospital Executive Board.

However, the further development of the Corporate Risk Assurance Framework profile identifying the key significant risks for the Trust enables better prioritisation and more informed decision making by the Board of Directors.

It is acknowledged, and important that the Trust takes measured risks to move the organisation forward to achieve the best possible results and services for the Hospital and its patients.

8.0 MONITORING

Compliance with the Risk Management Strategy will be monitored through an annual report for the previous financial year to the Trust Corporate Governance Group.

The report will be prepared by the Deputy Director of Nursing, Quality & Risk and Governance Manager and will monitor:

- The key individuals for risk management are discharging their responsibilities in line with the Strategy through attendance at key risk management committees and minutes of those meetings
- The high level risk committees have discharged their responsibilities in line with the relevant Terms of Reference including reporting arrangement into the committee and the committees reporting arrangements into the Board of Directors as identified in the Board Planner
- The Board of Directors and high level risk committee(s) review the organisation wide risk register as identified through minutes of the appropriate meetings
- How all risks are assessed using a standard template and Trustwide grading matrix in line with the Risk Management Strategy
- How risk is managed locally through review of incident reporting, compliance with the Trustwide annual clinical and non clinical risk assessment process and evidence of maintenance of local risk registers and presentation of those to the Corporate Governance Group

Where deficiencies have been identified, an action will be developed and monitored on a quarterly basis through the Corporate Governance Group.

9.0 REFERENCES

- Foundation Trust Monitor Terms of Authorisation (May 2014)
- The Foundation Trust Code of Governance (December 2013, updated July 2014)
- 'Equity & Excellence: Liberating the NHS' July 2010,
- 'Building an Assurance Framework: a practical guide for NHS Boards' (March 2003)
- '7 Steps to Patient Safety' (NPSA 2004)
- NPSA Being Open (July 2006)
- CQC Regulation 20 Duty of Candour
- Healthcare Commission investigation into Maidstone and Tunbridge Wells (October 2007)
- Lord Darzi's review High Quality Care for All (June 2008)
- Healthcare Commission investigation into Mid Staffordshire A&E (March 2009)
- "Taking it on Trust" (April 2009)
- Francis Report (February 2013)
- Keogh Report (July 2013)
- Berwick Report (August 2013)
- *National Guidance on Learning From Deaths , a Framework for NHS Trusts & NHS Foundation Trusts on Identifying, Reporting, Investigation & Learning from Deaths in Care, March 2017*

APPENDIX A

RISK GRADING MATRIX

The risk grading matrix is used by staff for both the grading of incident, complaints and claims and all annual risk assessments. Individual risk incidents are graded by the appropriate line manager and reviewed in the Risk Management Office by the Governance Manager and Head of Patient Safety. The Trust Incident & Risk Assessment Grading Matrix was originally developed and adapted from the Controls Assurance Guidance 'Risk Register Scoring System' (December 2003) as follows:

Table 1 – Consequence Score (C)

	1	2	3	4	5
Descriptor	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Objectives / Projects	Insignificant cost increase/schedule slippage. Barely noticeable reduction in scope or quality	<5% over budget/schedule slippage. Minor reduction in quality/scope	5-10% over budget / schedule slippage. Reduction in scope or quality	10-25% over budget / schedule slippage. Doesn't meet secondary objectives	>25% over budget / schedule slippage. Doesn't meet primary objectives.
Patient/Staff Safety	Minor injury not requiring first aid	Minor injury or illness, first aid treatment required	RIDDOR / Agency reportable	Major injuries, or long term incapacity / disability (loss of limb)	Death or major permanent capacity
Patient Experience	Unsatisfactory patient experience not directly related to patient care	Unsatisfactory patient experience readily resolvable	Mismanagement of patient care	Serious mismanagement of patient care	Totally unsatisfactory patient outcome or experience
Complaints / Claims	Locally resolved complaint	Potential claim Justified complaint peripheral to clinical care	Potential claim Justified complaint involving lack of appropriate care	Likely claim Multiple justified complaints	Multiple claims or single major claim
Clinical Service / Business Interruption	Local interruption with back up	Local interruption	Loss/interruption > 1hour	Loss / interruption > 8 hours	Loss / interruption > 24 hours
Staffing & Competence	Short term low staff level temporarily reduces service quality (<1day)	Ongoing low staffing level reduces service quality	Late delivery of key objective/service due to lack of staff. Minor error due to poor training. Ongoing unsafe staffing level	Uncertain delivery of key objective / service due to lack of staff. Serious error due to poor training.	Non-delivery of key objective / service due to lack of staff. Loss of key staff. Critical error due to insufficient training
Financial	Small loss	Loss >0.5% of budget	Loss >1% of budget	Loss >3% of budget	Loss >5% of budget
Inspection / Audit	Minor recommendations. Minor non-compliance with standards	Recommendations given. Non-compliance with standards	Reduce rating. Challenging recommendations. Non-compliance with core standards	Enforcement Action. Low rating. Critical report. Major non-compliance with core standards	Prosecution. Zero rating. Severely critical report
Adverse Publicity / Reputation	Rumours	Local media – short term. Minor effect on staff morale	Local media – long term. Significant effect on staff morale	National media < 3 days	National media >3 day. MP concern (Questions in House)
Information Governance	Damage to individuals reputation, possible media interest Potentially serious breach, less than 5 people affected of risk assessed as low	Damage to a team's reputation. Some local media interest, may not go public Serious potential breach and risk assessed high. Up to 20 people affected	Damage to a services reputation/low key media coverage Serious breach of confidentiality, ie. up to 100 people affected	Damage to organisation's reputation/local media coverage Serious breach with either particular sensitivity or up to 1,000 people affected	Damage to NHS reputation, national media coverage Serious breach with potential for ID theft or over 1000 people affected

Instructions for Use

- Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk
- Use Table 1 (see over) to determine the Consequence score(s) C, for the potential adverse outcome(s) relevant to the risk being evaluated
- Use Table 2 (see over) to determine the Likelihood score(s) L, for those adverse outcomes
- Table 3 shows the Grading Matrix for the calculated risk (C X L)

If possible, score the likelihood by assigning a predicted frequency of the adverse outcome occurring. If this is not possible, then assign a probability to the adverse outcome occurring within a given time frame such as the lifetime of the project or the patient care episode

Table 2 – Likelihood Score (L)

	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability	<9%	10-24%	25-49%	50-74%	75-100%
	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not

Use the risk matrix shown below to determine the actual grading of the risk.

Risk Matrix R (risk) = C (consequence) x L (likelihood)

Table 3 - Trust Grading Matrix

Likelihood	Consequence				
	1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

The Matrix Graph will give a scored risk rating of either:

Extremely High	=	Purple
High	=	Red
Moderate	=	Orange
Low	=	Green

This rating is used for both populating the Corporate/Local Risk Assurance Frameworks and for scoring all incidents, complaints and claims on the Datix Information System. This approach ensures that all risk analysis is based on the same assessment criteria and allows like for like comparison of all risks to the Trust. Training is provided for all staff that have responsibility for the categorisation grading and scoring of risks.

All high and extremely high graded incidents will require consideration for a formal root cause analysis to be carried out and where appropriate risks will be added to the Corporate Risk Register. (see Root Cause Analysis Guidelines)

Table 4 – Management Levels of Authority

Risk Colour	Remedial Action	Decision to accept risk	Risk Register level
Green Low	Ward Manager/ Head of Department	Ward Manager/ Head of Department	Clinical Speciality
Orange Moderate	Associate Director Head of Service Head of Nursing/Clinical Matron	Clinical or Exec Director Corporate Governance Group	Trust Wide
Red High	Associate Director Head of Service Director	Executive Team	Trust Wide
Purple Extremely High	Director	Executive Team	Trust Wide

APPENDIX B

Management of Risk Locally

The Trust Governance/Risk Management Strategy 2015 - 2018 refers to having effectively established a Corporate & Directorate level Risk Assurance Frameworks. The NHSLA Risk Management Standards (January 2012) 1.1.5 recommend that all organisations should have an organisation-wide approved Risk Register which must include the source of the risk, including incident reports, risk assessments and directorate risk registers.

An annual clinical & non clinical risk assessment is undertaken by all departments and specialities and the most significant risks used to populate the Trustwide Risk Assessment and both local and corporate risk assurance frameworks. The source data to populate the local risks assurance frameworks can be derived from a number of areas including:

- the annual directorate business planning process when the significant risks in achieving the objectives within the business plan at a directorate level can be identified
- annual clinical & non clinical risk assessments
- directorate review meetings
- performance reviews
- risks arising from incident reporting
- risks arising from external review or inspections
- recommendations from internal audit reports
- Patient surveys
- Staff surveys
- Risks shared by neighbours and/or other stakeholders

Local Risk Assurance Frameworks

The Governance Manager provides training and advice to Managers regarding the establishment of local risk assurance frameworks supporting newly appointed staff, ensuring the development of a consistent approach across the organisation.

The post holder assists the Associate Directors/Heads of Service in the development and on-going management of local risk registers, advising any changes in line with new national guidance.

The Governance Manager holds a central record of local risk assurance frameworks that have been submitted to the Corporate Governance Group for review. As with the Corporate Risk Assurance Framework, the Associate Directors/Heads of Service/Clinical Directors are accountable for identifying:

- ✔ the level of risk
- ✔ the adequacy of the controls in place
- ✔ agreed actions to be taken (including action plans)
- ✔ progress to date

Identified risks will initially be graded for their impact at a Directorate level using the Trust's Grading Matrix (Appendix A).

Local level risk assurance frameworks are reviewed on a monthly basis by the Corporate Governance Group where any risks grading 'high' or 'extremely high' at a Directorate level will be reviewed by the Executive Directors for their Trustwide impact and where appropriate, added to the Corporate Risk Assurance Framework.

Local risk assurance frameworks should be 'live' documents and regularly reviewed by the Associate Directors/Head of Service and monitored through the appropriate Directorate/Departmental group i.e. Clinical Governance Committees.

APPENDIX C

Frimley Health
Directorate/Departmental Clinical Governance Framework

All Directorates/Departments are required to establish a multi-disciplinary sub-committee of the Trust Clinical Governance Committee to ensure the implementation and monitoring of local compliance with the Trust clinical governance and risk management arrangements.

Directorates/Departments should hold at least quarterly Clinical Governance & Risk Management meetings. The meetings will be chaired by a senior manager or consultant for the directorate and will include representation from all clinical and non-clinical areas within the directorate together with representation from the wider multidisciplinary team i.e. therapies, pharmacy, infection control.

Agendas for these meetings will be determined locally but should, as a minimum, consider the following Standing Agenda Items:

- Directorate/department incident reporting profiles including serious incidents, actions identified, sharing of learning, audit of changes in practice
- Outcomes from Morbidity & Mortality reviews
- Patient experience including complaints, claims & concerns highlighting actions identified, sharing of learning & audit of changes in practice
- Compliance with relevant mandatory training and how areas of non-compliance are being addressed
- Clinical audit programme including local and national speciality audits
- Local risk assurance framework which should reflect safety & quality risks
- Compliance with and implementation of national guidelines & standards including NICE guidance, quality standards and pathways
- Directorate process in terms of managing locally owned clinical guidelines and policies which should include key lead, date for review and providing updated information on the Trust intranet
- Directorate process in terms of managing locally owned Patient Information which should include key lead, date for review and providing updated information on the Trust intranet

Minutes of meetings
Minutes of meetings should demonstrate a record of attendance at the meeting, the discussions that have taken place and any actions that have been agreed with leads and dates recorded. These actions should be followed up and carried forward if not closed. Where standing items as per the Terms of Reference, are not discussed, these should be noted in the minutes as a nil return.

Reporting
Directorates/Departments will report to the Trust Clinical Governance Committee on an annual basis with reports structured under the headings of the 5 CQC domains, i.e Safe, Effective, Caring, Responsive & Well-Led.

The well-Led section should include governance arrangements including local roles and responsibilities, committee structure, attendance and frequency of directorate Clinical Governance meetings as well as levels of staffing, appraisals and training rates and sickness.

Appendix D

Frimley Park Hospital NHS
NHS Foundation Trust

BOARD OF DIRECTORS

- Commercial Development & Investment Committee
- Audit Committee (Assurance)
- Finance Assurance Committee
- Nominations Committee
- Performance & Remuneration Committee
- Quality Assurance Committee

- Hospital Executive Board (Operational)
  - Finance & Performance
  - Capital Planning
  - Information Governance
  - Health, Safety & Environment
  - Equality & Diversity
- Corporate Governance Group (Risk)
- Clinical Governance Committee (Clinical Assurance / CQC)
  - Clinical Speciality Annual Assurance Reports
    - Directorate Clinical Governance Groups
  - Drugs & Therapeutics
    - Medications Safety
  - Organ Donation
  - End of Life
  - Clinical Audit & Effectiveness / NICE
  - Infection Control
  - Research & Development
  - Medical Devices / Decontamination
  - EPRR / Business Continuity
  - Training & Development
  - Blood Transfusion
- Quality Committee (Responsible for Quality Improvement Plan)
  - Morbidity & Mortality
  - Speciality M & M
  - Resuscitation & Deteriorating Patient
  - Patient Safety Committee
  - Patient Experience
  - Safeguarding

Governance Structure