Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD
28th May 2012

TITLE	**The Quality, Safety and Risk Management Strategy (Draft)**
EXECUTIVE SUMMARY	The Quality Safety and Risk Management Strategy aims to strengthen the Trust's quality process. Following an extensive review and analysis of current systems, significant changes to the current strategy have been made around management of compliance with the CQC Essential Standards, Risk Management Processes and improving clinical outcomes. The Draft Strategy has been out for consultation and is being discussed at the Trust Executive Committee on 25th May 2012. The Board will be updated on any final conclusions from TEC at the Board meeting.
BOARD ASSURANCE (Risk) / IMPLICATIONS	The Trust's CQC Review of Compliance Report, the Trust's Quality Risk Profile and the most recent Dr Foster Good Hospital Guide Publication have raised concerns about the safety and quality of our services.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	The proposed changes and improvements have been considered and approved by the Trust Executive Committee. Patients and their carers would be the beneficiaries of these changes and improvements
EQUALITY AND DIVERSITY ISSUES	None identified
LEGAL ISSUES	None identified
The Trust Board is asked to:	Approve the Strategy which includes the following significant changes: • The new committee structure and Quality Governance Board • The new Risk Management Process and the Risk Scrutiny Committee • CQC Compliance management capabilities.
Submitted by:	Mrs Heather Caudle, Associate Director of Quality on behalf of Mrs Suzanne Rankin and Dr David Fluck
Date:	22nd May 2012
Decision:	For Decision

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

The Quality Safety and Risk Management Strategy

2012 - 2017

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

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1. Introduction

This paper will describe the strategy for Quality, Safety and Risk Management in Ashford and St. Peter's Hospitals NHS Foundation Trust (ASPH) by answering three key questions:

- What does ASPH need?
- What is the vision?
- What are the building blocks?

During 2011/12 the Trust identified areas of improvement in line with national standards set by both the NHS Litigation Authority (NHSLA) Risk Management Standards. Care Quality Commission (CQC) regulatory framework and the National Patient Safety Agency (NPSA) standards for incident management. As such systems have been reviewed and robust systems designed for the timely management of incidents and Serious Untoward Incidents and include:

1. A stronger focus on safety assessment and management in particular the use of risk registers and the Board Assurance Framework (BAF)
2. The Trust culture with regard to risk management and safety needed to be more proactive and allowing Divisions and Departments responsibility to manage their individual risks
3. Continuing to work effectively with other agencies such as NHSLA, CQC, NPSA and the Health and Safety Executive.
4. Staff roles, responsibilities, knowledge and training with regard to risk management and including the support of staff following a serious incident.

This strategy therefore aims to provide a vision and clarity about the quality, safety and risk management culture of the Trust. It promotes the absolute importance of safety. It outlines staff roles and responsibilities and describes the systems and processes for effective risk management.

The Strategy must be read in conjunction with the Trust's Maternity Risk Strategy. Further to the Quality, Safety and Risk Management Strategy, there will be the development of the Patient Experience and Engagement Strategy.

The implementation of the strategy will be outlined with a detailed schedule following the outcome of the consultation of the strategy.

1.1 What does ASPH need

1.1.1 The national context.

The quality of care remains the central organising principle for the Trust. Lord Darzi defines quality across three dimensions:

Patient Safety

Clinical Effectiveness

Patient Experience

In his introduction to the Next Stage Review, Lord Darzi said *"High quality care should be as safe and effective as possible, with patients treated with compassion, dignity and respect. As well as clinical quality and safety, quality means care that is personal to each individual"* (Department of Health 2008).

1.1.2 The National Quality Board

In 2009, the Department of Health established the National Quality Board (NQB) bringing the Department of Health, the Care Quality Commission (CQC), Monitor, the National Institute for Health and Clinical Excellence (NICE) and the National Patient Safety Agency (NPSA) together to look at the risks and opportunities for quality and safety across the whole health system.

The NQB has now published three papers:

- *'Reviewing Early Warning Systems: Acute and Community'*. (February 2010). This paper reviews systems and processes in place for safeguarding quality in the NHS following the publication of a report by the Healthcare Commission confirming serious failings at Mid Staffordshire NHS Foundation Trust

- *'Maintaining and Improving Quality during the Transition: safety, effectiveness, experience'.* (March 2011). This paper examines the support process as the NHS undergoes major structural change to a new system architecture.

- *'Quality Governance in the NHS: A Guide for Provider Boards'.* (March 2011).

1.2 What is the vision

The vision of the organisation is to be **one of the best** healthcare Trusts in the country, which is underpinned by the values of the organisation, the 4Ps:

Patients First

Personal Responsibility

Pride in our Team

Passion for Excellence.

Quality and Efficiency will share an equal partnership with patients at the heart of everything we do.

1.2.1 Why a vision?

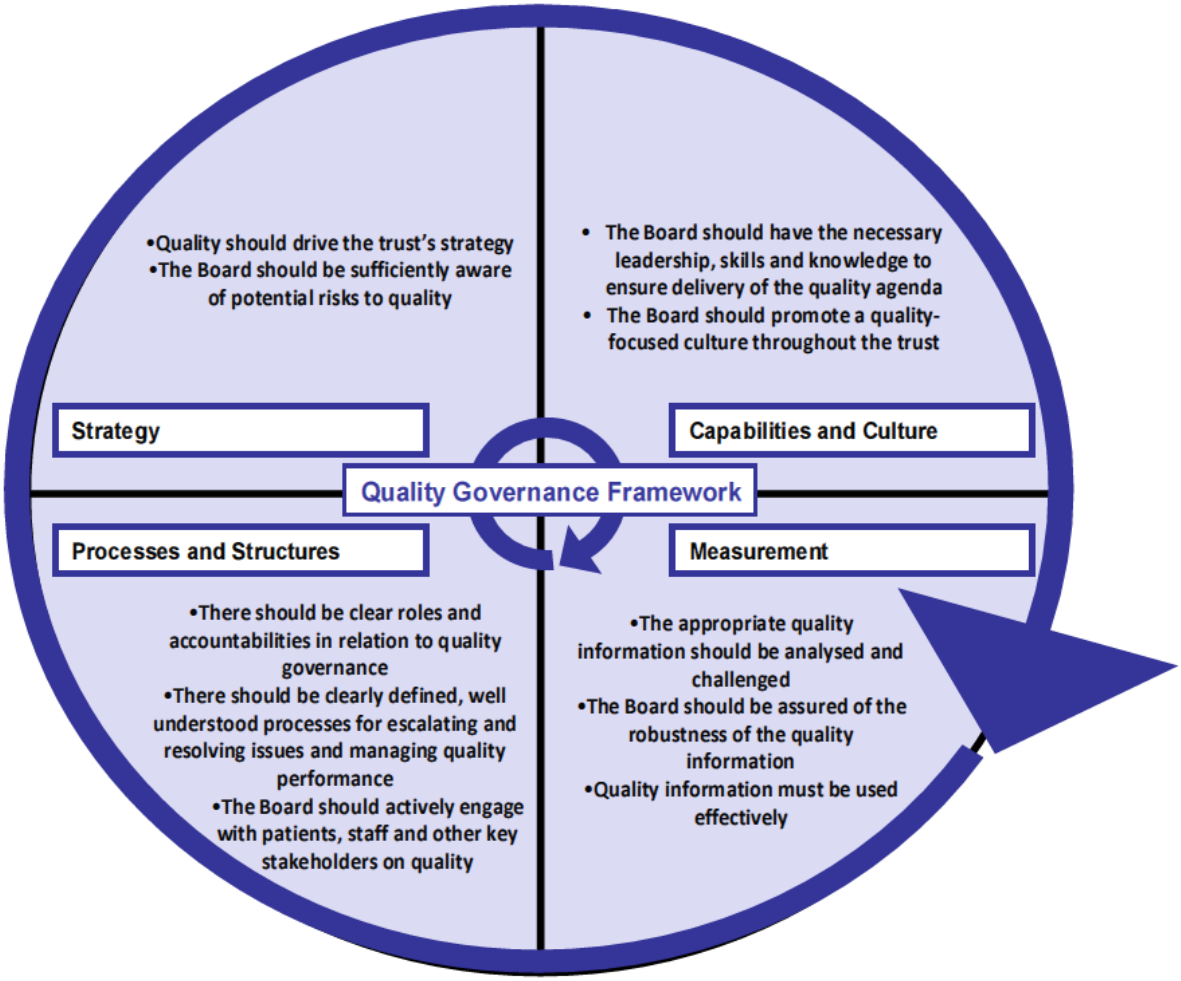
The publication *'Quality Governance in the NHS: A Guide for Provider Boards'* (March 2011) sets out the main intentions around quality:

- To define quality governance and give shape to what it means to govern for quality across an organisation;

- To provide support to Provider Boards in achieving and delivering this quality governance;

- To identify and provide links to further publications, documents and concepts that provide detail on supporting aspects of quality governance.

The guide requires Provider Boards to discuss the NQB publications at Board level and to undertake a self-assessment assurance process to satisfy themselves that the needs of quality governance within the organisation have been fully met.



Source: 'Quality Governance in the NHS: A Guide for Provider Boards'

1.2.2 Analysis of need

The Trust conducted a gap analysis of its current position against the principles set out in the Quality Governance Framework. The results of that gap analysis have informed the development of this Quality, Safety and Risk Management Strategy.

This Quality, Safety and Risk Management Strategy is the result of that review and the main changes proposed have been around the following:

- Divisional ownership of quality and risk management structures and committees.
- Strengthened processes for assessing and monitoring compliance with essential standards and national guidelines.
- Formulated reporting mechanisms and measures of effectiveness around risk management.
- Improved and modernised patient engagement and involvement strategies to ensure alignment and where possible integration.

1.3 What are the building blocks

The Strategy will make good use of the Quality Governance Framework and will describe its:

- Strategy, Vision and Purpose
- Leadership, Capabilities and Culture
- Processes, Structures and Engagement
- Measurement, Analysis and Assurance

2 Strategy, Vision and Purpose – *Patients First*

2.1 One of the best

Taking forward that vision are the five Trust Strategic Objectives. Strategic Objective 1 is ***to achieve the highest possible quality of care and treatment for our patients*** and one of the priorities is to develop and implement a Trust wide quality strategy to deliver this.

Figure 1 is a diagram showing the alignment of the Trust's values to the NQB's Quality Governance Framework thus showing the Trust's strategic vision for Quality.

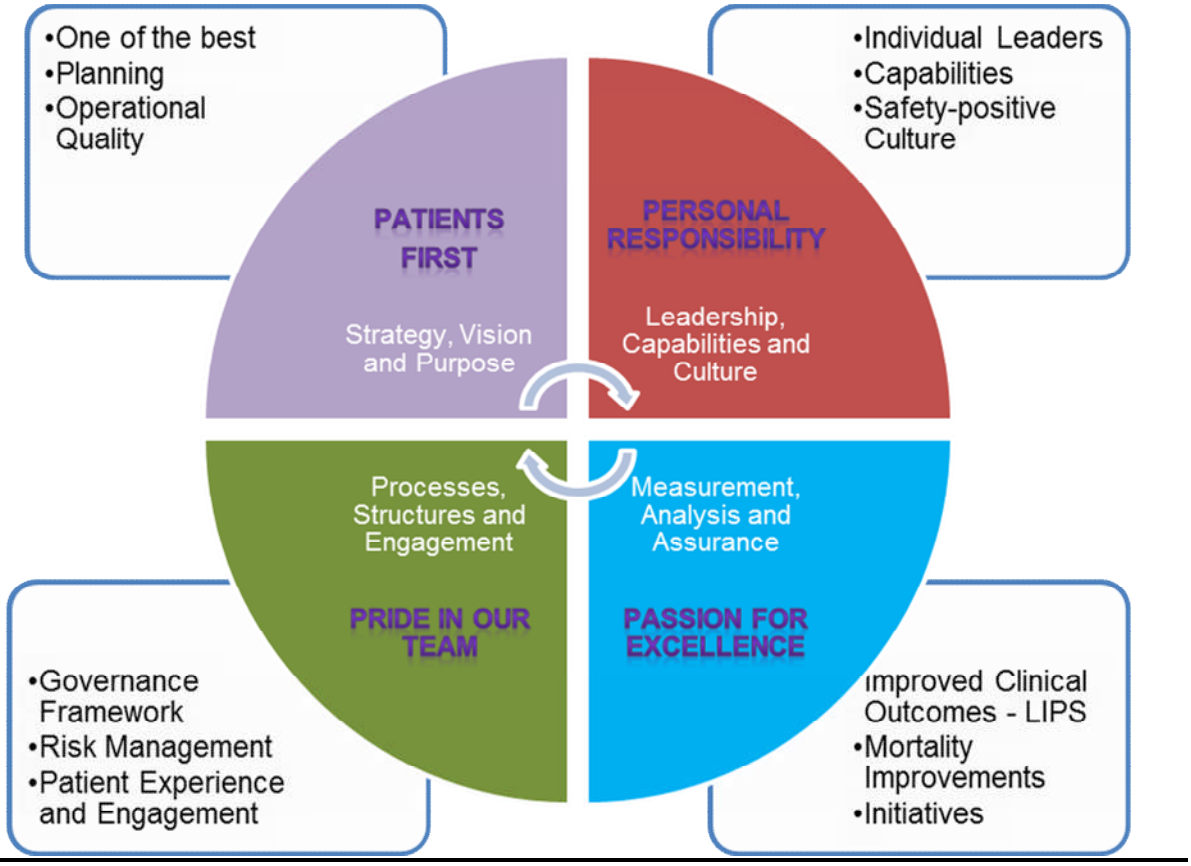


Figure 1 – Delivering Quality through our Values

The Strategy will be implemented over the next five years and within that time the following will be realised.

- A new meeting structure, Appendix 1
- A devolvement of quality governance and improvement.
- The Trust's Workforce, Patients and Carers work hand in hand to operate robust and efficient governance structures and processes underpinned by measurement and an open and just culture.
- Every patient is safeguarded from preventable harm and experiences the highest quality treatment and care.

Appendix 2 outlines the milestones of delivery of the Strategy.

2.2 Planning

The Annual plan will have Quality improvement objectives as the highest priorities and the Annual Quality Accounts will highlight what has been achieved. The setting of these priorities will undergo careful planning and statutory, as well as wider, stakeholder consultation. Throughout the year the Trust will monitor these improvements and, through work stream and priority leads, ensure we keep on track with committed improvements.

2.3 Operational Quality

The Trust aims to bind quality and operational performance together and to change the historical separation of these two elements of service provision.

The Trust will minimise risks to patients and staff and all its stakeholders through robust internal controls within a comprehensive and integrated system of risk identification, assessment and management. It will put steps in place to reduce avoidable harm.

The Trust's corporate and clinical governance systems will ensure effective risk management systems are in place.

The Trust recognises that positive and managed risk taking is essential for growth, development and innovation. "Risk" should never be set as a barrier to change and improvement; instead risks should be recognised, thought about and managed effectively as part of the continual improvement process.

Two ways this will be achieved are:

I. **Safety and Quality Impact Assessments** being undertaken for each operational redesign, CIP plan or new policy. Similarly, all patient and other safety improvement initiatives will have an assessment of whether any efficiency and/or financial contribution will be made if successful e.g. impact on reduced length of stay if a radical reduction in infections, pressure ulcers or falls is achieved.

II. **Performance and Quality Review Meetings** occurring every month at Divisional level. The current Performance Review Meetings will now be augmented to include the scrutiny and review of quality, safety and risk management issues, concerns and achievements.

3 Leadership, Capabilities and Culture – *Personal Responsibility*

Leaders in the organisation have a vital role to promote Quality, Safety and Risk Management as the highest priority for the Trust. They will do this in a number of ways to ensure that it is authentic and that the message is continuously reinforced by the Board and its individual Leaders' actions and behaviours.

3.1 Individual Leaders

TRIUMVIRATE LEADERSHIP OF QUALITY

Triumvirate leadership approach, which sees a tripartite sharing between a doctor, a nurse or allied health professional and an operational manager, is demonstrated both at the executive level to the divisional level. There are two more triumvirate level to be instituted to extend from the corporate level: Deputy Medical Director, Associate Director of Quality and Associate Director of Performance Improvement; to the face of care: clinical specialty lead, matron and clinical governance manager. These two further levels of triumvirate leadership of quality will support the organisation to deliver care of the highest quality and safety.

QUALITY ADVISORS

To maximise the intelligence and insight that corporately analysed and collated patient experience feedback, incidents, risk trends and audit results can provide, each division will have a quality advisor to provide that intelligence to help with the governance of quality, safety and risk issues within the divisions. This new role will work hand in hand with the divisions to provide the information and analyses required for routine (monthly, quarterly) review as well as any deeper reviews.

As these roles will be an extension of existing resources, careful scoping of what is required and what can be realistically provided will be negotiated between the divisions / department and the Quality Department and in accordance with the most recent Quality Department restructure.

Appendix three describes in details the roles and remit of the key leadership roles that will exist at every stratum of the Trust.

3.2 Capability

The Strategy will work alongside the organisational development plan to build capacity in the Trust commensurate with the ambition to make quality everyone's business. Leadership

development will aim to develop staff at team level to foster high performing teams across the organisation.

The expectation is that all staff:

- will have the responsibility to contribute to good quality governance by complying with all Trust policies and procedures and reporting incidents and near misses.
- are responsible for identifying risk, and either reporting this to their manager or putting the risk on the risk register they manage.
- should attend relevant mandatory training on risk management, patient safety and incident reporting.

3.3 Safety-positive Culture

A Safety-positive culture will ensure that all staff are empowered to intervene to safeguard patients, carers and colleagues from actual or potential harm. Improving safety culture in a patient area takes time and there are a number of tools available to help us measure the culture across an organisation. The Trust will initially establish a baseline assessment of culture in the Trust by using the **Manchester Patient Safety Assessment** to provide a snapshot during 2012.

The Trust will then use the results to determine what actions are needed to improve in which areas. The tool can be very helpful in a “before and after” assessment where the initiatives in chapter five of the text are being implemented. The best hospitals strive to achieve a positive score of 80% in each Division/Department and hold their Leaders to account for achieving this. Specific goals for Ashford and St Peter's will be established after the base line survey has been conducted.

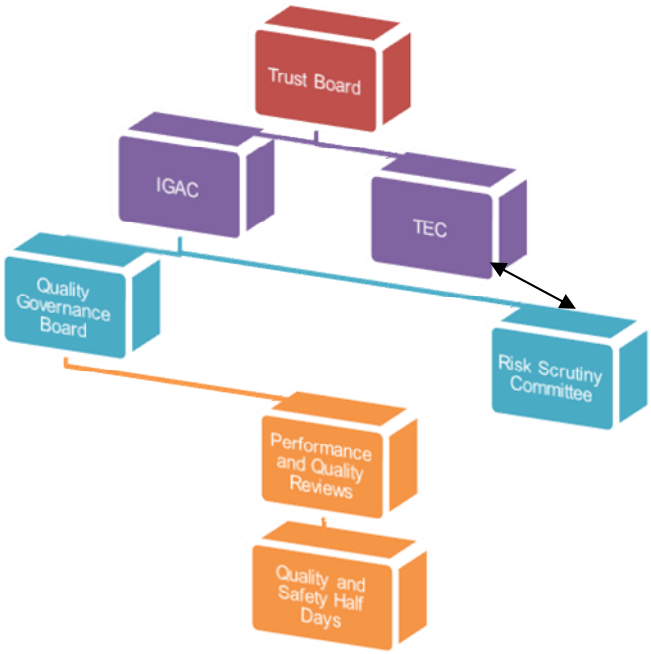
- <u>OPEN AND “JUST” CULTURE</u>

At all times staff must maintain their professional standards. The Trust wants staff to work in a supportive environment in which they are encouraged to report mistakes or concerns they have; especially those that affect the safety of our patients. Clearly, if they feel they are going to be “punished” for doing so, it is unlikely that they will proceed willingly.

If staffs make an honest mistake, they should not be punished for this. Instead, the incident should be seen as an opportunity for the organisation to learn and change things to try to avoid a repetition. Key to this is an organisation with a high reporting culture. The implementation of DatixWeb will improve the level of incident reporting.

Appropriate adjustment of punity in the context of innocent one-off mistakes should not be confused with holding staff to account for delivering to a professional standard. There may need to be action such as re training or appropriate supportive mechanisms to that individual. It is inappropriate to resort to disciplinary action for staff making, and reporting, a genuine mistake. Disciplinary action MAY occasionally be needed for persistent non-compliance with professional standards or for wilful disregard of Trust protocols or accepted professional practice.

4 Processes Structure and Engagement – *Pride in our Team*



4.1 Governance Framework

QUALITY, SAFETY AND RISK MANAGEMENT STRUCTURE

The review of the current Integrated Quality, Governance and Risk Management Structure has highlighted the need for a more robust governance framework. The new framework would therefore augment clinical governance and risk management at divisional level and thus the remit of the Clinical Governance Committee. The Clinical Governance Committee will now be called the Quality Governance Board (QGB).

Level 1, comprises of the six committees which report directly to the Trust Board and have particular responsibility for providing assurance to the Board. One of these Committees is the Integrated and Governance Committee, to which the QGB reports.

Level 2, comprises of two committees, Quality Governance Board and the Risk Scrutiny Committee which provide assurance to the Integrated Governance Assurance Committee (IGAC), in relation to clinical services provision and delivery of standards, via the reporting Committees, Groups and Divisions.

Level 3, comprises of the divisions, divisionally aligned committees and specialist committees that are responsible for overseeing the various elements of the Trust's services.

Appendix four describes in detail the Governance Structure.

COMMITTEE AND GROUPS POLICY

The Committees and Groups Policy sets out how the Committees and Groups will operate, sets out details of how each strand of the structure reports to its parent Committee, and provides standard paperwork.

INTEGRATED GOVERNANCE ASSURANCE COMMITTEE (IGAC)

The Integrated Governance Assurance Committee is the Committee of the Trust Board with the responsibility for gaining assurances in relation to risk controls for clinical risks, non-clinical risks, and corporate risk. It is the main committee through which the organisation is assured that risks are mitigated, through appropriate control mechanisms, and adequate assurance is provided that the Trust is running an effective and safe business.

The Committee will meet quarterly and has the following responsibilities:

1 To monitor the committees responsible for safety and clinical risk, clinical development and clinical effectiveness, through the Quality Governance Board (QGB). The Medical Director and Chair of the QGB will report to IGAC as per the Committee and Group policy.

2 To monitor the committees responsible for non-clinical risk, including the Health and Safety committee and its sub committees, through the Risk Scrutiny Committee(RSC) The Chief Nurse and Chair of the RSC will report to IGAC as per the Committee and Group policy.

3 To receive any feedback from the Audit Committee following their review of the Corporate Risk Register, and the BAF. To act upon any issues raised by Audit Committee following Audit recommendations.

4 To monitor the progress against Essential Standards. A review of the standards will be provided via the Associate Director of Quality and a more detailed exception report provided by the executive sponsor as required.

5 To receive a detailed report on Serious Incidents Requiring Investigations (SIRIs), and confirm closure of a SIRI is appropriate.

6 To monitor the risk associated with external reviews and inspections and oversee completion of action plans following recommendations.

7 To monitor the Risk Register and request action where necessary.

8 To actively review the BAF and make recommendations and changes where necessary.

9 To provide minutes of the meeting, and the Corporate Risk Register to the Audit Committee to ensure the Audit Committee has relevant information with which to be assured of the adequacy of the process and to be aware of the corporate risks and their appropriate management. The Audit Committee can request further information or action as necessary.

10 Make recommendations to the Trust Board on actions required to mitigate risks to organisation and reduce harm to patients and staff.

11 Provide an annual report to the Trust Board describing the actions the Committee has taken to ensure review of risk.

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AUDIT COMMITTEE

The Audit Committee is a sub-committee of the Board. The Committee has responsibility for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole organisation's activities, and for ensuring that the system supports the achievement of organisational objectives.

The Audit Committee has the following responsibilities:

- To ensure there is an effective internal audit function; the Committee has the primary responsibility for the recommendations made by the external and internal Auditors.
- To report to the Trust Board and maintain direct links into the IGAC.
- To review the minutes of the IGAC, in order to discharge their duties as identified in the Audit Committee's Terms of Reference.
- To review the Corporate Risk Register. The Committee has the authority to request further information around the corporate risks, or to request IGAC to review the Corporate Risk Register, in light of any information the Committee has received

The information provided by IGAC should enable the Audit Committee to demonstrate the scrutiny and challenge that is required in order to demonstrate effective governance and internal control.

ANNUAL GOVERNANCE STATEMENT

The Annual Governance Statement discloses the on-going process for identifying, evaluating and managing the significant risks faced by the Trust. The document includes an acknowledgement that the Trust Board is responsible for the Trust's system on internal control and for reviewing its effectiveness. The Audit Committee acts on behalf of the Board to maintain continuous assurance of the systems of internal control throughout the year. The Director of Finance and Information is responsible for the final statement. The Chief Executive is the Accounting Officer and as such is ultimately accountable for the Annual Governance Statement.

INTERNAL AUDIT

Internal audit provides an opinion on the governance and assurance processes. This includes the opinion on the adequacy of the BAF, the risk management arrangements, and on the adequacy of assurance for the Essential Standards. The internal auditors' opinion also forms part of the Annual Governance Statement (AGS). The internal auditors' annual review will be received by the Audit Committee and IGAC and recommendations discussed. Action plans implemented will be monitored by the Audit Committee quarterly.

EXTERNAL AUDIT

The external auditors are required to review the AGS with consideration as to whether the Annual Governance Statement has been prepared in line with the DoH requirements. The external auditors will identify any inconsistencies between the AGS and any information they

are aware of in relation to financial arrangements. The auditors will also consider the governance arrangements in place.

QUALITY GOVERNANCE BOARD (QGB)

The Quality Governance Board reports to IGAC (a formal standing sub-committee of the Trust Board). The QGB is established to steer the strategic and operational implementation of Governance within the Trust, ensure the Trust continues to undertake continual quality improvement and achieves compliance with the Essential Standards of Quality and Safety (Care Quality Commission registration) as well as incremental adjustments associated with the NHSLA Risk Management Standards. Membership will be at Board and Divisional Triumvirate Management level and will have responsibility for overseeing progress and assurance for clinical quality standards. The QGB will also:

- Support operational management teams within the Trust in implementing Governance, risk management and safety processes and improvements.
- Provide a level of scrutiny of quality governance arrangements including compliance with the Essential Standards of Quality and Safety compliance (Care Quality Commission registration).
- Ensure standards are clear through consideration of the Divisional Quality Dashboards.
- Ensure the escalation of any areas of concern to the Trust Executive Committee, IGAC and / or the Audit and Assurance Committee, as appropriate.

Divisions will conduct an annual presentation to the QGB with a full report on the Performance and Quality Reviews. The QGB will review Divisions' risk registers at every quarterly meeting to provide input into action plans and progress and to ensure risks are appropriately mitigated. Where further actions are required, the QGB will request an update on those actions at the next meeting or earlier if required.

Please see the Quality, Safety and Risk Management structure in Appendix four.

RISK SCRUTINY COMMITTEE

The Risk Scrutiny Committee (RSC) provides a steer to the Trust Executive Committee (TEC) regarding high-level risks on the Board Assurance Framework, Corporate Risk Register and risks escalated by the Divisions. The Group ensures that there is appropriate scrutiny and challenge associated with the review of risks prior to their inclusion onto the Trust's Corporate Risk Register Board / Assurance Framework or de-escalation to a Divisional level.

The Committee also ensures adequate support is provided to Divisions through the Executive Director sponsorship for each high level risk accepted for entry onto the Corporate Risk Register from the Divisions or corporate functions. Divisional and Corporate Department Risk Review groups report by exception to the RSC.

Together with the QGB, the RSC has responsibility for overseeing the Committees or Groups shown in the safety and risk arm of the Quality, Safety and Risk Management structure (see Appendix four). The QGB will ensure adequate assurance is provided to IGAC to assure the Committee, Audit Committee and Trust Board and that all quality related regulation requirements are being met, or being actioned, where appropriate.

The RSC has responsibility for considering the themes identified from incident reporting, and ensuring Directorate issues and learning relating to clinical incidents are shared across the Directorates and wider organisation.

The RSC will co-ordinate relevant benchmarking activities relating to key reports from the Care Quality Commission or National Patient Safety Agency (NPSA).

The Risk Scrutiny Committee will replace what is now called the Safety and Risk Committee.

STANDARDISED MORTALITY REVIEWS

The Trust-wide standardised process of reviewing, within a month, every death is underway. This does not replace more detailed Mortality and Morbidity Meetings (divisions may choose to integrate both types of meeting). The main purpose of the Mortality Review is to identify those cases where an alternative outcome may have resulted if an alternative approach or service delivery method been adopted. This will identify opportunities for improvement and service development.

4.2 Risk Management

BOARD ASSURANCE FRAMEWORK (BAF)

The Board Assurance Framework (BAF) provides the Trust with a simple but comprehensive method for the effective and focused management of the principal risks to meeting its corporate objectives. (Department of Health 2006).

The BAF is the key source of evidence that links controls and assurances to the corporate objectives. The Trust Board will use this in discharging its overall responsibility for internal control. Controls, assurances, gaps in controls and assurances and progress against closing those gaps will be reported to the Trust Board. This process underpins the Trust's Annual Governance Statement.

The Board Assurance Framework will be a dynamic document and controls, gaps in controls and progress against closing those gaps will be regularly reported to the Trust Board.

The Executive Director with lead responsibility for the BAF is the Chief Executive.

The full BAF will be actively reviewed at the quarterly IGAC and presented to the Trust Board at each Trust Board quarterly.

SCORING OF RISK – RISK MATRIX

Table one is the Risk Scoring Matrix.

The scoring of risk should be undertaken by a senior manager to ensure it accurately reflects the level of risk. Divisional Directors /Heads of Departments/Associate Directors/General Managers/ Matrons/Heads of Nursing/ Ward sisters have authority to assess the level of risk and score as appropriate.

The Risk Matrix is a generic matrix, which is used to assess the full range of risks, i.e., clinical, non-clinical, operational, strategic, and financial. The use of a risk matrix facilitates the identification of the level of the individual risk being considered. All risks are considered

in terms of; how likely it is that the risk would occur (likelihood) and, if it did happen, what level of injury or damage is likely to be sustained (severity).

The Trust's 5 x 5 risk matrix is recommended by the National Patient Safety Agency and Appendix five describes this in detail complete with qualitative measures.

Table 1: Risk Scoring Matrix R(risk) = C(Consequence) x L(Likelihood)

		Consequence				
Likelihood		1 None	2 Low	3 Moderate	4 Severe	5 Catastrophic / Death
Rare	1	Green 1	Green 2	Green 3	Yellow 4	Yellow 5
Unlikely	2	Green 2	Yellow 4	Yellow 6	Orange 8	Orange 10
Possible	3	Green 3	Yellow 6	Orange 9	Orange 12	Red 15
Likely	4	Yellow 4	Orange 8	Orange 12	Red 16	Red/Red 20
Certain	5	Yellow 5	Orange 10	Red 15	Red/Red 20	Red/Red 25

RISK REGISTER

The Risk Register is the Trust's record of the process of risk identification, analysis, evaluation, prioritisation and treatment process and is the basis for the Trust's risk management planning.

The risk register is the repository for all identified risks. The risk register holds the local risk registers for the Divisions and service departments as well as the Corporate Risk Register.

The General Managers have the authority to place a risk on the risk register and are required to sign off each risk register notification form.

RISK REVIEW

Local Risk Register

Local risks are owned by General Managers, and departmental leads. Divisional Directors /Heads of Departments/Associate Directors/General Managers will manage their area's local risks on a regular basis and report any changes to the management line.

Risk will be managed throughout the Trust at every level and owned at the level of management that is appropriate for the risk score.

The local risk registers are reviewed by QGB and the RSC. New local risks and all high local risks are reviewed by IGAC.

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Corporate Risk register

Identification of a risk deemed to be a corporate risk (i.e. organisational wide risk, or high or extreme risk) must be identified to the relevant manager and executive lead. Only an Executive Director has the authority to place a risk on the Corporate Risk Register.
The risk will be reviewed at Trust Executive Committee (TEC) prior to being placed on the Corporate Risk Register and discussed at the RSC.

Table two is the Management of Risk in the organisation.

Table 2: Management of Risk

Risk Rating	Remedial Action	Decision to accept risk	Risk Register Level
Green 1 – 3 Very Low Risk	Ward/Dept. Manager	Ward/Dept. Manager	Care Specialties Division
Yellow 4 – 6 Low Risk	Care Specialties /Dept. Manager	Care Specialties /Dept. Manager	Care Specialties Division
Orange 8 – 12 Moderate Risk	Divisional Management Team	Divisional Management Team	Division
Red 15 High Risk	Divisional Management Team	Divisional Management Team	Division
Red 16 High Risk	DMT/Executive Director	TEC/Trust Board via ERSG	Division or Corporate
Red/Red 20-25 Extreme Risk	Executive Director/CEO	TEC/Trust Board via RSC	Corporate

PROCESS FOR HIGH LEVEL COMMITTEE REVIEW OF RISK (CRR & BAF)

- The Risk Scrutiny Committee (RSC) reviews the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) on a quarterly basis.

- Prior to the quarterly meetings the Executive Directors meet on a 1:1 basis with the Head of Corporate Affairs and Head of Patient Safety to review and update their risks, risk scores and action plans on the BAF and CRR.

- This information is fed into a risk log, which forms part of the papers for discussion at the quarterly RSC where the rationale for risk closure, increasing or decreasing or risk scores or escalating risks to the BAF is recorded and documented. Risk escalation from Divisional Leads for inclusion on the CRR is also considered.

- The BAF and CRR are revised post this meeting and sent with recommendations to the Trust Executive Committee (TEC) for approval prior to being agreed by the Trust Board on a quarterly basis. IGAC also review these papers quarterly.

- Risks are also identified through sources such as complaints, claims, incidents and external reports and feed into the risk management process. Data for these functions (excluding external reports) is held on the Datix system.

- Twice a year there will be a forum discussion and deep analysis of one or two risks for the organisation to develop and review corporate action plans for Trust-side risk and safety issues. This will be organised by the Risk Scrutiny Committee.

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THE ROLE OF DIVISIONS / CORPORATE DEPARTMENTS / SPECIALTIES / WARDS OR CLINICAL AREAS

1 It is the responsibility of the Division / Corporate Departments / Specialties / Wards or Clinical areas to undertake risk assessments identify and reduce risks as part of routine management practice. This includes using data from the review of incidents, complaints, claims, business cases, external / internal reviews, reports and any other appropriate feedback.

2 Divisions / Corporate Departments / Specialties / Wards or Clinical areas are responsible for validating, prioritising and identifying solutions to their risks. Where immediate solutions are not possible these are then entered onto the risk register.

3 Divisions / Corporate Departments / Specialties / Wards or Clinical areas nominated persons will directly access and update their own Risk Registers via Datix.

4 Divisions / Corporate Departments / Specialties / Wards or Clinical areas s are responsible for ensuring that actions plans are effectively implemented to reduce and mitigate risk and that these are monitored regularly.

5 Each Divisional Management team / relevant corporate department will meet quarterly with Risk Scrutiny Committee to review the Divisional / Corporate Department Risk Register, risk scores, controls / assurances and action plans

6 Divisions / Corporate Departments / Specialties / Ward or Clinical areas should only escalate risks to the group they report to or the Risk Scrutiny Committee and TEC if, after local management action, a residual level of risk remains which is considered above the threshold of acceptance. In the case of escalation to RSC and TEC this must also be done if a risk can only be owned and managed at a corporate level. Risks for escalation must be signed off by the Divisional Performance and Quality Review Meeting or relevant Executive Director.

7 Divisional Performance and Quality Review Meetings and corporate departments should review their Risk Registers regularly (at least quarterly).

8 Divisional Triumvirate Leads should scrutinise and validate their risks:

- Before submission of reports to RSC/TEC
- At regular intervals to ensure that action plans are being implemented and risks mitigated.

9 All senior managers and middle managers should use their local Risk Register as a management tool and ensure that the risk registers are used to inform the annual business planning process.

RISK CONTROL AND ACTION PLANNING

Managing risks involves identifying the range of options for mitigating the risk, assessing those options, preparing risk management action plans and implementing them.

The following risk management options, which are not necessarily mutually exclusive or appropriate in all circumstances, can be applied:

- **Avoid** the risk – deciding not to proceed with the activity likely to generate risk (where this is practicable).

- **Mitigate / Reduce** the likelihood of the risk materialising – e.g. through contract conditions, audit and compliance programmes, policies and procedures, preventative maintenance, supervision, training etc. Funding of these controls will also need to be considered.

- **Reduce the potential consequences** if the risk does materialise e.g. through contingency planning, minimising exposure to the risk, public relations, relocation of activity.

- **Refer** the risk to RSC or back to the Division / corporate department for further action.

- **Defer** a decision until the receipt of further information.

- **Transfer of Risk** – this involves another party bearing or sharing some part of the risk e.g. through the use of contracts, insurance arrangements and organisational structures such as Service Level Agreements (SLAs).

- **Accept** and monitor the risk – after risks have been controlled, reduced or transferred, there may be risks that are retained. Plans should be put in place to manage the consequences of these retained risks. In some cases risks that cannot be reduced or transferred will need to the "accepted" by the Trust QGB or the Divisional Performance and Quality Review Meeting. These retained risks will be reviewed through the processes outlined in this document.

All Trust Risk Registers and the Board Assurance Framework are "live" documents and each change is recorded so that an audit trail of risks and changing risk ratings is available, therefore all risk ratings are current and based on the controls and assurances in place when rating the risk.

Table 3: Summary of Risk Grading Process

No harm/ damage	Low Harm/ Damage	Moderate Harm/ Damage	Severe Harm/ Damage	Catastrophic Harm Damage

Step 1: what is the potential **consequence** of the event/risk if the event/risk is realised?
Step 2: What is the **likelihood** of this event occurring again or the risk being realised?
Step 3: What is the overall **risk score** (colour category) for this event?
Step 4 What **controls and assurances** are in place to mitigate the risk? Do these reduce the likelihood or consequence of the risk being realised and therefore reduce the risk score?

The 'colour category' & risk score assigned determines the desired level of Investigation required & the management accountability level attributable to the event / risk.

4.3 Patient Experience and Engagement

The Secretary of State, Andrew Lansley, has made it clear:

"… that patients must be at the heart of everything we do, not just as beneficiaries of care, but as participants, in shared decision-making. As patients, there should be no decision about us, without us".

The Quality, Safety and Risk Management Strategy will support the Trust to deliver this challenging agenda by driving work aimed at ensuring the meaningful participation of patients, both in their care and in helping us to improve our services.

To ensure patient and carer participation from the outset we will:

- Involve patients in our quality strategy.
- Ensure patient representation at the high level Quality Governance Board.
- Ensure patient participation in developing a Patient Experience and Engagement Strategy.
- Support patients by ensuring they have the resources and skills to enable meaningful engagement and participation

To support the Trust in achieving meaningful patient and carer participation the following tools will be developed:

- A patient and carer engagement template and toolkit.
- Source of information, evidence and guidance on TrustNet.
- A two-year project to implement a Shared Decision-Making (SDM) approach across the Trust.

To measure progress in this area the following metrics will be used:

- Survey – to establish baseline and progress relating to patient and staff experience of both engagement and SDM.
- For SDM – a triangulation of data relating to length of stay, mortality and patient experience (National Survey question regarding SDM).
- Establish baseline for evidence of local patient engagement mechanisms in each Division.

5 Measurement, Analysis and Assurance – *Passion for Excellence*

5.1 Improving Clinical Outcomes – Leading Improvements in Patient Safety

It is essential that the Trust's multi-disciplinary clinical body is involved in the development of the Quality and Safety Strategy. The revitalised vision, structure and processes will aim to create a culture build upon the Trust 4Ps, where clinical quality is everybody's business and we all put patient safety first. The Trust will commit to a quantifiable and ambitious goal, aimed at the reduction of its mortality rate and "harm free care".

This will be achieved mainly through the Trust's current engagement with the NHS Institute's Leading Improvement for Patient Safety Programme 1 (LIPS) alongside regular engagement with the Trust Executive

Pre-existing champions and work such as Doctors Advancing Patient Safety (DAPS) and the Best Care Programme will continue and be integrated into the Strategy and approach.

The agenda is in development but will include opportunities for divisional/clinical speciality leads to consider their own quality and safety priorities and improvement actions so that development work and ultimately the Strategy is generated and "owned" by the organisation.

5.2 Mortality Improvements

MORTALITY CODING AND INFORMATION TRAIL

Coding of deaths is completed by a senior clinician and preferably a Consultant prior to a junior doctor's completion of the death certificate. This will be underpinned by more accurate coding of the data that eventually enters national databases and on which organisations like Dr Foster base their analysis of the Trust's performance.

QUALITY AND SAFETY HALF DAYS

Significant resources in the form of a half day per month will be invested in the Trust for multidisciplinary teams to dedicate to improving clinical outcomes.

The purpose of the sessions is to consider key aspects of **patient safety, experience and outcomes** including:

- Mandatory Training
- Morbidity and Mortality (to be attended by all consultants contracted to work on that day)
- Serious Incidents Requiring Investigations.
- Clinical audit, research and development
- Team reflection, building and development as a learning organisation

The attendance, content and outputs of these sessions are integral to the quality governance boards and performance review meetings.

The format of each Division's Quality and Safety Half day will be carefully co-produced with the Medical Director, Chief Nurse, Deputy Medical Director and Associate Director of Quality together with the Divisional Directors within three months of this strategy.

CLINICAL OUTCOMES STEERING GROUP

This monthly forum is chaired by the Medical Director and receives the mortality review data from each specialty within each division. A Dr Foster advisor to the Trust will attend and support the group. The remit of the group will be to underpin improvements in clinical quality and to utilise externally published and locally held quality performance data to inform progress and priorities.

5.3 Initiatives

BEST CARE PROGRAMME

A project is in design as part of the Best Care Programme that aims to ensure nursing staff undertake, record and interpret clinical monitoring of patients appropriately. This work aims to ensure that deteriorating patients are quickly identified and escalated to the appropriate clinical decision maker so that rapid and effective intervention can be initiated. In the first instance roving ward based road shows that raise awareness and signpost best practice will be implemented in early March. At a later date a Clinical Decision Support Tool will be scoped.

CAMPAIGN TO PROMOTE EARLY DECISION MAKING

In early consideration and for discussion as part of the Quality, Safety and Risk Management Strategy development is a campaign to promote early clinical decision making, predominantly by junior doctors but also other healthcare professionals that is designed to lead to the early initiation of high impact care bundles such as the Septic Resuscitation and Management Care Bundle. Early thoughts, very much open to discussion, are that a campaign using the pneumonic “DECIDE” could be utilised to promote a series of questions that clinicians use to promote early decision making.

***“DECIDE – to act*” – consider?**
D - deliberate ordered decision making – decide to act
E – early intervention – rapid initiation of high impact care bundle
C – ceiling of care (DNACPR) or a best interest discussion (MCA)
I – does your patient have an existing integrative /continuing care package – does this need to be secured to enable rapid discharge
D – diagnostics – decide on what adds value, arrange and follow-up
E – is this patient at end of life – consider choice of place of death

DIVISIONAL IMPROVEMENT TEAMS

Informed by routine and commissioned audits and as part of the Leading Improvements in Patient Safety, each division will action improvements in quality and safety through Divisional Improvement Teams.

The improvements will be reported as part of Performance and Quality Review reports and lead to a decentralised, Trust – wide approach to quality assurance and improvement.

6 Conclusion

The Trust's vision is to be one of the best healthcare organisations in the country by providing joined-up healthcare, with patients at the centre of everything it does.

The National Quality Board's Governance Framework provides the building blocks of

- Strategy, Vision and Purpose
- Leadership, Capabilities and Culture
- Processes, Structures and Engagement
- Measurement, Analysis and Assurance

Against which the Trust will deliver its vision of quality though the Trust's values of Patients First, Personal Responsibility, Pride in our Team and Passion for Excellence.

Through more robust risk management processes and a further devolvement of quality, safety and risk management, the Trust will embed a culture where Quality is everybody's business.

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APPENDIX 1 – Schedule of IGAC, QGB, RSC and Performance and Quality Meetings

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
IGAC			**IGAC**			**IGAC**			**IGAC**		
	Risk Scrutiny Committee	**Quality Governance Board**		**Risk Scrutiny Committee**	**Quality Governance Board**		**Risk Scrutiny Committee**	**Quality Governance Board**		**Risk Scrutiny Committee**	**Quality Governance Board**
		AM/AE **A/CC** Annual Reports			**WH/P** Annual Report			**SM/SS** **S** Annual Reports			**D/T** **T/O** Annual Reports
Performance & Quality Review Groups	Performance & Quality Review Groups	Performance & Quality Review Groups	Performance & Quality Review Groups	Performance & Quality Review Groups	Performance & Quality Review Groups	Performance & Quality Review Groups	Performance & Quality Review Groups	Performance & Quality Review Groups	Performance & Quality Review Groups	Performance & Quality Review Groups	Performance & Quality Review Groups

Quality Governance Board	Dashboard Report	Mortality Reviews	External Published Data	CQC	Pt Feedback Dashboard	Incident Trends
Risk Scrutiny Committee	BAF	CRR	Claims			

Divisions:	Acute Medicine & Emergency Medicine	**AM/AE**
	Anaesthetics & Critical Care	**A/CC**
	Specialist Medicine & Specialist Surgery	**SM/SS**
	Diagnotics & Therapeutics	**D/T**
	Surgery	**S**
	Trauma & Orthopaedics	**T/O**
	Women's Health & Paediatrics	**WH/P**

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APPENDIX 2 – MILESTONE DELIVERY OF YEAR ONE

Phase	Aim	Task	Objective	Responsibility	Deadline	Completed
1	Vision – Approve the Strategy	Approve Strategy	Submit Quality Safety and Risk Management Strategy to the Trust Executive Committee for approval.	Suzanne Rankin / Heather Caudle	May 12	
			Disseminate copy of the Strategy to the Divisional General Manager, Heads of Nursing and Corporate Co-ordinators Group	Suzanne Rankin / Heather Caudle	May 12	
	Processes – Implement Quality Safety and Risk Management Structure	Re-define Quality-related Committee Structure	Review governance structure with clear reporting lines between sub-committees of the Board, directorate management boards and other committees	Suzanne Rankin / Heather Caudle	July 12	
			Review terms of reference for the sub-committees and groups pertaining to quality, safety and risk management.	Suzanne Rankin / Heather Caudle	July12	
			Review timings and frequency of quality related boards, sub-committees of board, groups and Divisional meetings relating to quality, safety and risk management.	Suzanne Rankin / Heather Caudle	July 12	
			Implementation of Datix Web	Suzanne Rankin / Heather Caudle	Oct 12	
		Assess the Safety Culture	Determine Baseline Measurement of Safety Culture using the Manchester Patient Safety Assessment	Suzanne Rankin / Heather Caudle	Dec 12	
			Evaluate the positioning of Risk Scrutiny Committee as a sub-committee of the Integrated Governance and Assurance Committee	Suzanne Rankin / Heather Caudle	June13	
	Capabilities – Delivering High	Define Service lines / Division	Prepare detailed guidance on the role of the Divisional Performance and Quality	Suzanne Rankin / Valerie Bartlett /	July 12	

	Performance Teams to deliver high Quality and Safe Care	Quality structure.	Review meetings, including agenda items, action plans and reporting to Quality Governance Board	Heather Caudle / Claire Braithwaite / David Fluck / Mick Imrie		
		Define service line leadership roles and training of Senior management, Divisional Triumvirate and Clinical Specialty leads	Provide training on risk management methodology and how to apply to Board, sub-committees of the Board, other committees and Trust Executive Committee.	Suzanne Rankin / Raj Bhamber / Heather Caudle	Dec12	
			Complete training programme for building capabilities of Divisional Triumvirate, Clinical specialty leads and Matrons on quality governance.	Suzanne Rankin / Raj Bhamber / Heather Caudle	Dec 12	
			Patient Experience and Engagement Strategy.	Suzanne Rankin / Heather Caudle	Dec 12	
			Embed Health Assure for Provider Compliance Management	Suzanne Rankin / Heather Caudle	June 12 to Dec 12	
	Measurement for Improvement – Improving Outcomes quality	Improve methodology for quality performance tracking validating	Co-produce the Quality and Safety Half days with developed KPIs for Divisions, specialties and wards.	Suzanne Rankin / David Fluck / Mick Imrie / Heather Caudle	June12	
			Evaluate and determine external benchmarking support required.	David Fluck / Heather Caudle	May 12 and on-going	
			Launch Leading Improvements in Patient Safety Programme.	Suzanne Rankin / Marty Williams	May 12	
			Implement Improvement initiatives.	Suzanne Rankin /	June12 –	

				David Fluck	May 13	
			Implement Dr Foster patient level activity tracker and adapt for staff feedback.	David Fluck / Heather Caudle	May 12	
			Introduce Dr Foster patient experience data and adapt for both staff and patient feedback.	Suzanne Rankin / Heather Caudle	Dec12	

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APPENDIX 3 – ROLE DESCRIPTIONS IN QUALITY, SAFETY AND RISK MANAGEMENT

1. TRUST BOARD

The Board should set appropriate policies on Quality, Governance and Risk Management and regularly assure itself that the appropriate processes are functioning effectively to monitor the risks the Trust is exposed to. The Trust must also assure itself that the system of Integrated Governance is effective in reducing the risks to an acceptable level. Key responsibilities are

- Review the effectiveness of the Trust's internal control using the Board Assurance Framework
- Monitor performance and ensure corrective action
- Ensure financial stewardship
- To ensure dialogue with external bodies and the local community.

2. CHIEF EXECUTIVE

The Chief Executive has overall responsibility for ensuring that the systems and process for Quality, Governance and Risk Management are in place, and that assurance for this process is provided to the Board.

3. EXECUTIVE DIRECTORS

The Executive Directors are responsible for the development of robust Quality, Governance and Risk Management arrangements for the Trust, ensuring that systems and structures meet statutory and legal responsibilities, and that they are based on good practice and guidance from governing and advisory bodies.

4. DIRECTOR OF FINANCE AND INFORMATION

The Director of Finance has the following responsibilities:

- Responsibility for the strategic development and operational management of the Trust's financial control, and the assurance of that system.
- Responsibility for the organisation's Annual Governance Statement.
- Responsibility for the strategic development and operational management of information, and for ensuring that there are robust systems and processes to provide adequate information governance.

5. CHIEF NURSE

The Chief Nurse has the following responsibilities

- Responsibility for ensuring effective quality governance processes are in place (jointly with the Medical Director)
- Responsibility for ensuring adequate clinical governance systems and processes are in place (jointly with the Medical Director)
- Responsibility for ensuring that the Trust has a robust organisational risk management process in place, and that this works effectively.
- Responsibility for ensuring that there are systems in place for the management of clinical and non-clinical risk.

- Responsibility for ensuring that there are robust systems and processes to manage the assurance for Essential Standards of Quality and Safety and the NHSLA/CNST Risk Management Standards.
- Responsibility for ensuring Quality, Safety and Risk Management Strategy, Patient Engagement and Experience Strategy and the Maternity Risk Strategy are in place
- Executive Lead on the Trust Board for Maternity Services

6. MEDICAL DIRECTOR

The Medical Director has the following responsibilities

- Responsibility for ensuring effective quality governance processes are in place (jointly with the Chief Nurse)
- Responsibility for ensuring adequate clinical governance systems and processes are in place (jointly with the Chief Nurse)
- Caldicott guardian

7. DIRECTOR OF WORKFORCE AND ORGANISATIONAL DEVELOPEMENT

The Director of Workforce and Organisational Development has responsibility for the strategic development of the workforce and for ensuring staff governance is in place in line with statutory requirements.

8. DEPUTY CHIEF EXECUTIVE

The Deputy Chief Executive has the following responsibilities

- Responsibility for ensuring the effective implementation of the strategy within the organisation's Divisions
- Responsibility for ensuring adequate risk operational management is evident within the Divisions.
- Executive Lead for Health and Safety

9. NON EXECUTIVE DIRECTORS

Non-executive Directors have a duty to ensure that the Trust has sufficient control measures to be able to effectively manage its risk.

10. HEAD OF CORPORATE AFFAIRS

The Head of Corporate Affairs has responsibility for administration of the Board Assurance Framework. The Head of Corporate Affairs also offers advice and guidance to the Trust Board and Council of Governors on compliance and regulation.

11. ASSOCIATE DIRECTOR OF QUALITY

The Head of Quality and integrated Governance has the following responsibilities

- Responsibility for the operational process for Quality, Safety and Risk Management.
- Responsibility for the operational process for Clinical Governance

12. ACCOUNTABLE OFFICER (AO) FOR CONTROLLED DRUGS

The AO is involved in the investigation of all controlled drugs (CD) related incidents, takes responsibility for any decision to report to/involve the police where theft/abuse or fraud is suspected and reports to/represents the Trust on the Local Intelligence Network.
This responsibility covers:

- All aspects of CD activity including storage, issue, prescribing, administration,
- The safe, appropriate and effective management and use of controlled drugs.
- TTOs – safe destruction and disposal
- All staff involved with CD management including pharmacy, nursing, medical, operating department and porters/transport.

13. CHIEF PARMACIST

The Chief Pharmacist is responsible for the organising, monitoring and reporting of a system for ensuring the safe and secure handling of medicines.
The responsibilities cover:

- The procurement of pharmaceuticals;
- Appropriate quality taking account of regional/national policies and
- The Trusts policies including the Standard Financial Instructions (SFIs)

14. HEAD OF PATIENT ENGAGEMENT AND EXPERIENCE

The Head of Patient Engagement and Experience has the responsibility for:

- Operational processes for Patient Advice and Liaison services (PALS) and Complaints
- The development of the Patient Engagement and Experience Strategy.

15. HEAD OF PATIENT SAFETY

The Head of Patient Safety has the following responsibilities:

- Responsibility for the operational process for management of risk
- Responsibility for the operational management of the Trust Risk register
- Responsibility for the Non-Clinical and Clinical Claims process
- Responsibility for the operational management of incidents including Serious Incidents Requiring Investigations (SIRIs).

16. HEAD OF CLINICAL EFFECTIVENENSS

The Head of Clinical Effectiveness has responsibility for the coordination of the Trust's clinical audit programme and compliance with the following

- Confidential Enquiries
- National and Regional Audits
- NICE guidance

17. HEAD OF ACCREDITATION AND REGULATION

The Accreditation and Compliance Manager has the following responsibilities:

- Responsibility for ensuring that the Trust's clinically regulated services and those of its internal and external partners are compliant with CQC regulatory standards.

- Responsibility for the development and delivery of solutions and support for the Trust to meet the criteria for regulatory standards.
- Responsibility for the provision of specialist advice on all aspects of compliance to areas subject to inspection or external reviews.

18. ASSOCIATE DIRECTOR OF HEALTH INFORMATICS

The Associate Director of Health Informatics is responsible for the accurate coding of patient diagnoses in liaison with medical and surgical staff to ensure accurate clinical information is available both within and external to the organisation.

Key responsibilities include the facilitation of the development of the Trust Quality Dashboards, the Patient Feedback dashboards, Quality Account and the Mortality records.

19. QUALITY ADVISORS

The Quality Advisors are members of the Quality Department who are assigned a division or department to provide quality, safety and risk intelligence from trust wide analysis of trends in quality, safety and risk data to enable routine and exceptional clinical governance of emergent and on-going risks and issues.

20. CLINICAL GOVERNANCE MANAGERS

The Clinical Governance managers are members of the Divisions who provide quality, safety and quality intelligence for their division and conduct patient experience, risk and quality investigations and audits as required, to facilitate routine and exceptional clinical governance of emergence and on-going risks and issues.

Two key partnerships:

- Head of Patient Safety – attend Clinical Governance Forums to review risks for their divisions.
- Associate Director of Informatics – to prepare and interrogate the Quality Dashboard in preparation for the monthly Performance and Quality Reviews and the Quarterly Quality Governance Board.

21. DIVISIONAL TRIUMVIRATE

All Senior Managers are responsible for implementing the Quality, Safety and Risk Management Strategy and for ensuring robust internal control and assurance systems are in place in their areas of responsibility. It is the responsibility of the General Managers to review the Division's risks on the risk register including the risk score; in particular risks scored from 8 to 18, to ensure that the risk register can be reviewed appropriately at the Integrated Governance and Assurance Committee (IGAC).

This pertains to:

- Divisional Directors
- General Managers

- Heads Of Nursing

22. HEADS OF DEPARTMENTS

Clinical Specialty leads, Matrons and Service Managers are responsible for the implementation of Trust policies and procedures. They are also responsible for implementing systems that meet statutory requirements and control risks; in particular risks rated 1 to 6. This pertains to:

- Matrons/ Service Managers
- Clinical Specialty Leads
- Ward Managers

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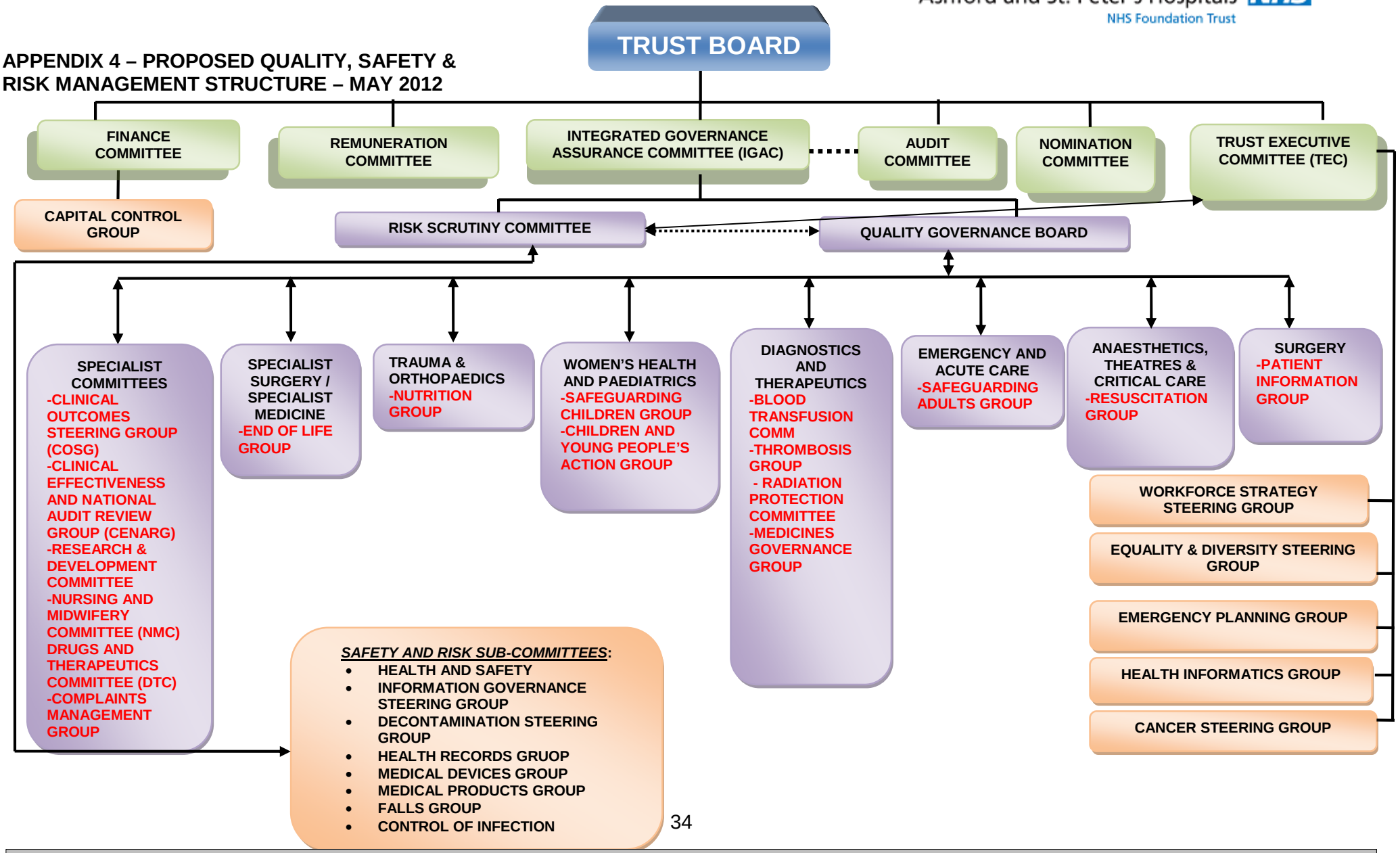
APPENDIX 4 – PROPOSED QUALITY, SAFETY & RISK MANAGEMENT STRUCTURE – MAY 2012



EMPLOYEE PARTNERSHIP FORUM
MEDICAL STAFFING COMMITTEE
PATIENT PANEL

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APPENDIX 5 – RISK SCORING MATRIX – EXAMPLES OF QUALITATIVE MEASURES OF SEVERITY/CONSEQUENCE OF RISK

LEVEL	DESCRIPTOR	Impact on the safety of patients, staff or public (physical/psychological harm) Human resources/ organisational development/staffing/ competence	Quality/complaints/ claims/ audit/Finance	Business objectives/ projects /Service/business interruption Environmental impact	Adverse publicity/ reputation Statutory duty/ inspections
1	**Negligible**	▪ Minimal injury requiring no/minimal intervention or treatment. ▪ No time off work ▪ Short-term low staffing level that temporarily reduces service quality (< 1 day)	▪ Peripheral element of treatment or service suboptimal ▪ Informal complaint/inquiry ▪ Small loss Risk of claim remote	▪ Insignificant cost increase/ schedule slippage ▪ Loss/interruption of >1 hour ▪ Minimal or no impact on the environment	▪ Rumours ▪ Potential for public concern ▪ No or minimal impact or breech of guidance/ statutory duty
2	**Minor**	▪ Minor injury or illness, requiring minor intervention ▪ Requiring time off work for >3 days ▪ Increase in length of hospital stay by 1-3 days ▪ Low staffing level that reduces the service quality	▪ Overall treatment or service suboptimal ▪ Formal complaint (stage 1) ▪ Local resolution ▪ Single failure to meet internal standards ▪ Minor implications for patient safety if unresolved ▪ Reduced performance rating if unresolved ▪ Loss of 0.1–0.25 per cent of budget ▪ Claim less than £10,000	▪ <5 per cent over project budget ▪ Schedule slippage ▪ Loss/interruption of >8 hours ▪ Minor impact on environment	▪ Local media coverage – ▪ short-term reduction in public confidence ▪ Reduced performance rating if unresolved ▪ Elements of public expectation not being met Breech of statutory legislation
3	**Moderate**	▪ Moderate injury requiring professional intervention ▪ Requiring time off work for 4-14 days ▪ Increase in length of hospital stay by 4-15 days ▪ RIDDOR/agency reportable incident ▪ An event which impacts on a small number of patients ▪ Late delivery of key objective/ service due to lack of staff ▪ Unsafe staffing level or competence (>1 day) ▪ Low staff morale ▪ Poor staff attendance for mandatory/key training	▪ Treatment or service has significantly reduced effectiveness ▪ Formal complaint (stage 2) complaint ▪ Local resolution (with potential to go to independent review) ▪ Repeated failure to meet internal standards ▪ Major patient safety implications if findings are not acted on ▪ Loss of 0.25–0.5 per cent of budget ▪ Claim(s) between £10,000 and £100,000	▪ 5–10 per cent over project budget ▪ Schedule slippage ▪ Loss/interruption of >1 day ▪ Moderate impact on environment	▪ Local media coverage – ▪ long-term reduction in public confidence ▪ Single breech in statutory duty ▪ Challenging external recommendations/ improvement notice
4	**Major**	▪ Major injury leading to long-term incapacity/disability ▪ Requiring time off work for >14 days ▪ Increase in length of hospital stay by >15 days ▪ Mismanagement of patient care with long-term effects ▪ Uncertain delivery of key objective/service due to lack of staff ▪ Unsafe staffing level or competence (>5 days) ▪ Loss of key staff ▪ Very low staff morale	▪ Non-compliance with national standards with significant risk to patients if unresolved ▪ Multiple complaints/ independent review ▪ Low performance rating ▪ Critical report ▪ Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget ▪ Claim(s) between £100,000 and £1 million ▪ Purchasers failing to pay on time	▪ Non-compliance with national 10–25 per cent over project budget ▪ Schedule slippage ▪ Key objectives not met ▪ Loss/interruption of >1 week ▪ Major impact on environment	▪ National media coverage with <3 days service well below reasonable public expectation ▪ Critical report ▪ Enforcement action ▪ Multiple breeches in statutory duty ▪ Improvement notices ▪ Low performance rating

		▪ No staff attending mandatory/ key training			
5	**Catastrophic**	▪ Incident leading to death ▪ Multiple permanent injuries or irreversible health effects ▪ An event which impacts on a large number of patients ▪ Non-delivery of key objective/service due to lack of staff ▪ Ongoing unsafe staffing levels or competence ▪ Loss of several key staff ▪ No staff attending mandatory training /key training on an ongoing basis	▪ Totally unacceptable level or quality of treatment/service ▪ Gross failure of patient safety if findings not acted on ▪ Inquest/ombudsman inquiry ▪ Gross failure to meet national standards ▪ Non-delivery of key objective/ Loss of >1 per cent of budget ▪ Failure to meet specification/ slippage ▪ Loss of contract / payment by results ▪ Claim(s) >£1 million	▪ Incident leading >25 per cent over project budget ▪ Schedule slippage ▪ Key objectives not met ▪ Permanent loss of service or facility ▪ Catastrophic impact on environment	▪ National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) ▪ Total loss of public confidence ▪ Severely critical report ▪ Multiple breeches in statutory duty ▪ Prosecution ▪ Complete systems change required ▪ Zero performance rating

Qualitative Measures of Likelihood of Risk

LEVEL	**DESCRIPTOR**	**TIME FRAME**	DESCRIPTION	
1	**Rare**	Not expected to occur for years	This will probably never happen/recur	The event **may** occur only in **exceptional circumstances**
2	**Unlikely**	Expected to occur at least annually	Do not expect it to happen/recur but it is possible it may do so	The event **could** occur at **some time**
3	**Possible**	Expected to occur at least monthly	Might happen or recur occasionally	The event **will** occur at **some time**
4	**Likely**	Expected to occur at least weekly	Will probably happen/recur but it is not a persisting issue	The event **will** probably occur in **most circumstances**

5	**Almost Certain**	Expected to occur at least daily	Will undoubtedly happen/recur, possibly frequently	The event is **expected** to occur in **most circumstances**

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Table 1: Risk Scoring Matrix R(risk) = C(Consequence) x L(Likelihood)

		Consequence				
Likelihood		1 None	2 Low	3 Moderate	4 Severe	5 Catastrophic / Death
Rare	1	Green 1	Green 2	Green 3	Yellow 4	Yellow 5
Unlikely	2	Green 2	Yellow 4	Yellow 6	Orange 8	Orange 10
Possible	3	Green 3	Yellow 6	Orange 9	Orange 12	Red 15
Likely	4	Yellow 4	Orange 8	Orange 12	Red 16	Red/Red 20
Certain	5	Yellow 5	Orange 10	Red 15	Red/Red 20	Red/Red 25

Risk Rating	Priority	Action timescale
Extreme	Urgent priority action	Immediate
High	High or Urgent priority action	Immediate to 48 hours
Medium	Medium Priority action	Within 4 weeks
Low	No or Low priority action	Within 6 months

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APPENDIX 6: GLOSSARY

Term	Definition
Annual Governance Statement	A system, maintained by the Board, that supports the achievement of the organisation's objectives. This should be based on an ongoing risk management process that is designed to identify the principal risk to the organisation's objectives, to evaluate the nature and extent of those risks, and to manage them efficiently, effectively and economically.
Assurance	Confidence, based on sufficient robust evidence, that internal controls are in place, operating effectively and objectives are being achieved e.g. internal and external audits and reviews.
Board Assurance Framework	A structure within which boards identify the **principal risk** to the organisation meeting its **principal objectives** and map out both the **key controls** in place to manage them, how they have gained sufficient **assurance** about their effectiveness and identify any **gaps** in **controls or assurances**.
Control	The systems used to manage and govern the organisation e.g. **policies and procedures** or **physical control**.
Current Risk Score	Within a Risk Register – which is a living document – risk scores may fluctuate dependent on many factors therefore a current risk score helps identify if a risk is decreasing or escalating.
External Assurance / Independent Assurance	Assurances provided by reviewers, auditors and inspectors from outside the organisation, such as **External Audit, NHSLA, CQC**, **MRHA or Royal Colleges** for example.
Gap in Assurance	**Failure to gain sufficient evidence** that policies, procedures, practices or organisational structures on which reliance is placed are operating effectively.
Gap in Control	**Failure to put in place** sufficient effective policies, procedures, practices or organisational structures to manage risk and achieve objectives.
Hazard	A **potential source or risk** e.g. damage or harm.
Integrated risk management	A process through which organisations identify, assess, analyse and manage all risk and incidents for every level of the organisation and aggregate the results at a corporate level e.g. patient safety, health and safety, complaints, litigation and other risks.
Internal Assurance	Assurances provided by reviewers, auditor and inspectors who are part of the organisation, such as Clinical Audit or management peer review.
Internal Control	The on-going policies, procedures, practices and organisational structures designed to provide reasonable assurance that objectives will be achieved and that undesired events will be prevented or detected and corrected.
Key Control	A control to manage one or more principal risks.
Mapping of Assurance	A process, providing a clear management and audit trail, that links • Principal objectives to principal risk. • Principal risk to key controls. • Key controls to assurances.
Mitigation / treatment of risk	Actions taken to reduce the risk or the negative consequences of the risk.
Negative Assurance	Evidence that shows risks are not being managed and / or controlled effectively e.g. poor external reviews or serious untoward incidents.
Positive Assurance	Robust evidence that shows risks are being reasonably managed and objectives are being achieved e.g. external audits, reviews etc.

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Term	Definition
Principal Objectives	Objectives set at strategic, corporate and directorate (or equivalent) level.
Principal Risk	A risk which threatens the achievement of Principal Objectives.
Prioritisation / Rating of Risk	A process by which risks are graded in order based on the likelihood of their occurrence and the impact of their consequences.
Residual Risk	The risk remaining **after risk control measures** have been taken, often reflected as the **current risk score**.
Retained Risk	Once the organisation has agreed their risk appetite and risk tolerance this will be **the level of risk they are prepared to accept**.
Risk	The combination of likelihood and consequence of hazards being realised, resulting in some form of loss or damage. The possibility that objectives will not be achieved.
Risk Analysis	The systematic use of information to identify hazards and to estimate risk.
Risk Assessment	The **identification and analysis of relevant risk**s to the achievement of objectives (comprises or risk analysis and risk evaluation).
Risk Control	The process in which decisions are made and measures implemented by which **risks are reduced** to, or maintained within, specified levels.
Risk Matrix (Risk evaluation/scoring system)	Tool used to help estimate **Likelihood x Consequence** resulted in an **overall risk score**.
Risk Management	A systematic process by which potential risk are identified, assessed, managed and monitored.
Risk Management Strategy / Policy	A document outlining how organisations, are and will, do their 'reasonable best' to manage themselves so as to meet their objectives and protect patients, staff, the public and other stakeholders against risks of all kinds.
Risk Register	A central register of the Trust's key risk that identifies the classification of risks by area, likelihood, consequence etc. The register also identifies who has responsibility for the risk and the actions being taken to manage it.
Risk Tolerance	How much risk the organisation can feasibly take.
Sources of Assurance	The various reviewers, auditors and inspectors, both internal and external, who carry out work at NHS organisations (see Internal Assurance and External Assurance). Boards will have to determine which sources of assurances are relevant to principal risks and to what extent they are sufficient.
Statement of Assurance	An annual statement signed by the Accounting Officer on behalf of the board that forms part of the Annual Financial Statements for the year. The Assurance Governance Statement provides public assurances about the effectiveness of the organisation's system of internal control.
Strategic Objective	An overall goal of the organisation.