East Sussex Healthcare NHS
NHS Trust

Risk and Quality Delivery Strategy

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Date ratified:	12/10/16 (Trust Board)
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Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1.0 2012038	January 2012	Margaret England	New organisation	Full revision
V1.1 2012179	August 2012	Emily Keeble	Organisational change and to meet compliance requirements	Altered to reflect changes in group structures including terms of reference many of which have been updated. Inclusion of patient safety group and divisional quality groups. Development of the monitoring arrangements.
V1.2	January 2013	Emily Keeble	Changes post-NHSLA inspection	Revised monitoring table
V1.3	February 2014	Emily Keeble/Lynette Wells	Annual Review	Removal of reference to NHSLA Replacement of Trust Strategic Objectives Replaced SIC with Annual Governance Statement Removal of reference to Divisions
V1.4	April 2015	Emily Keeble	Annual Review	Minor changes
V1.5	August 2016	Ashley Parrott	Reflect changes to structure and processes	Re-write and name change to incorporate two strategies into one (Governance Strategy)

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Quality and Safety Committee	Quality and Safety Committee	Sept 2016

Table of Contents

1. Statement of Intent

East Sussex Healthcare NHS Trust is committed to continuously improving the outcomes for its patients and achieving excellence in patient care. It recognises that it has a statutory and regulatory duty to ensure that systems of control and governance are in place to monitor and improve the quality of care provided and reduce the impact of any risks that could affect patient care, staff and the organisation.

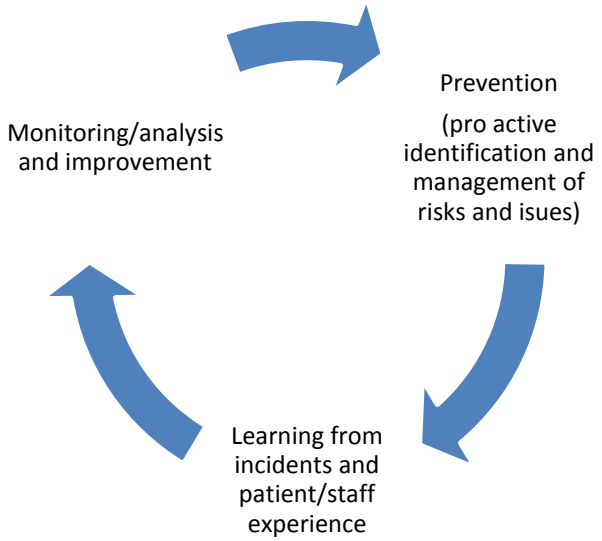
The Trust Board recognises that risk management is integral to good governance and management practice and is committed to ensuring this is firmly embedded within the culture of the organisation. As such, the Risk and Quality Delivery Strategy must be implemented throughout all levels of the organisation.

2. Introduction

The aim of the Risk and Quality Delivery Strategy is to outline the trust governance structure to support the delivery for the three domains of quality (patient safety, patient experience and clinical effectiveness) and to outline the systems in place to manage them effectively. This will be achieved through the effective use of core governance systems such as risk management, incident reporting, complaints management and audit and compliance. This document will provide the framework to deliver the trust Quality Strategy through central and Division/Clinical Unit governance structures.

This strategy is supported by a number of policies such as the Risk Management Policy and Procedure, Incident Reporting and Management Policy and Managing Complaints Policy and is also aligned to ESHT 2020 our Strategic Priorities for Improvement.

The system to support risk and quality delivery within the organisation is grouped into 3 core areas as shown below:



3. Strategic Objectives

The Trust vision statement is:

"ESHT combines community and hospital services to provide safe, compassionate, and high quality care to improve the health and wellbeing of the people of East Sussex."

To support the statement above there are 5 Key Strategic Objectives (KSO's) that are also detailed in the trust 20:20 strategy:

1. Safe patient care is our highest priority. We will provide high quality clinical services that achieve and demonstrate optimum clinical outcomes and provide an excellent care experience for patients.
2. All ESHT's employees will be valued and respected. They will be involved in decisions about the services they provide and offered the training and development that they need to fulfill their roles.
3. We will work closely with commissioners, local authorities, and other partners to prevent ill health and to plan and deliver services that meet the needs of our local population in conjunction with other care services.
4. We will operate efficiently and effectively, diagnosing and treating patients in timely fashion to optimise their health.
5. We will use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally, and financially sustainable.

Quality care has 3 specific domains which are:

- Patient Safety
- Patient experience
- Clinical effectiveness

4. The governance structure with specific committees and groups with quality and risk responsibilities

4.1 Governance Structure Chart

The structure chart below demonstrates the ward to board approach to governance with the central corporate functions providing support to deliver the 3 core areas.
The Trust has established a committee reporting structure based around the 5 key sections which are:

- Quality and Safety
- Leadership and culture
- Clinical Strategy
- Access and operational delivery
- Financial control and capital development

Within each of these sections there are specific committee/group structures as detailed in **Appendix A**. All these groups perform vital functions to ensure the delivery of high quality care. There are terms of reference in place reviewed annually for all the committees and groups within the trust that detail the specific functions, reporting arrangements, membership and frequency of meetings.

Governance Structure

Central Support

Prevention

- Risk register
- Risk assessment
- Staff skills, recruitment & training
- IT systems
- Compliance with national guidance and standards
- Polices

Learning from experience

- Incident management (investigations and identification of actions to improve)
- Patient feedback (FFT and Complaints, user forums, engagement)
- Staff feedback
- Claims/Inquests
- Mortality and morbidity reviews

Monitoring, Analysis and Improvement

- Audit
- Testing actions
- Improvement Hub

Trust Board

Strategic Development Group	**Quality & Safety Committee**	**People and Organisational Development Committee**	**Audit Committee**	**Finance and Investment Committee**

Executive Team

Quality and Safety	Leadership and Culture	Access and Delivery	Finance and Capital	Clinical Strategy

These are not specific groups/committees but the five sections defining the Governance Framework. Within each there is a committee structure. See Appendix A of this document.

Executive Team
Integrated Performance Reviews & Executive led meetings

Division/Clinical Unit

- Governance Meetings
- Risk Meetings
- Specialty Meetings

Corporate Team Meetings and Senior Leadership Forum
IT, Finance, Estates and Facilities, Clinical Administration, Human Resources, Corporate Teams

Feedback from incidents, complaints etc.

Wards/ Departments

- Operational issues, staffing, inquests, audits, objectives, roles and responsibilities.
- Risks, Incidents, complaints (reported on Datix)

4.2 Trust Board

The Board is accountable for ensuring the effectiveness of the risk management systems and internal controls within the Trust. The Audit Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness of purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and compliance with CQC registration standards. The Board is required to gain assurance that all risks have been identified and are being appropriately managed and the Board Assurance Framework appears on the Board agenda bi monthly. The Board is also responsible for the quality of care provided to patients and the safety of staff. This will be achieved through delegation of specific duties to sub committees and groups to monitor, challenge and embed change for continuous improvement. The Non-Executive Directors of the Board chair the senior committees within the trust to ensure healthy external challenge and assurance provided to decision making and identification of risks.

4.3 Audit Committee

The Audit Committee reviews the establishment and maintenance of an effective system of governance, 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 relation to its role in risk management the Committee will review the adequacy and effectiveness of:

- The Board Assurance Framework;
- The risk management system;
- The Annual Governance Statement together with an accompanying Internal Audit Statement (within Annual report and Quality Account);
- External audit opinion or other appropriate independent assurances, prior to discussion by the Board where possible.

4.4 Quality and Safety Committee

The Quality and Safety Committee ensure, on behalf of the Board, that taking account of best practice, there are effective structures and systems in place that support the continuous improvement of quality services, safeguard high standards of patient care and evidence effective risk management. This committee seeks assurance the safety and quality structure is effective and identifying, managing and improving risk and quality, and supporting the quality strategy. This committee will seek assurance on behalf of the Board the functions within the Trust are effective in their monitoring, analysis and response to quality and risk issues.

4.5 Finance and Investment Committee

Although high quality care will reduce cost through improved safety and effectiveness this committee will ensure on behalf of the Board the Trust has the appropriate finances to maintain a safe and effective system that can support quality improvement initiatives. It will also provide recommendations and assurance to the Board on:

- The future financial risks of the organisation
- The integrity of the Trust's financial structure
- Delivery of the Trust financial plan.

4.6 People and Organisational Development Committee

This Committee will ensure there is a managed programme for providing a skilled workforce that reacts early to planned and enforced changes in service delivery.

4.7 Strategic Development Group

The Strategic Development Group (SDG) is the group that will provide leadership and oversight to support ESHTs strategic plan. The group will ensure organisational alignment with national strategy, with the Sustainability and Transformation Plan (STP) and with the local commissioning intentions of East Sussex Better Together (ESBT).

4.8 Executive Team

The Trust Executive Team will be aware of the quality and risk concerns and successes for the Trust to respond swiftly where required and ensure the correct committee/group is managing the situation appropriately. This may be through an individual Executive Director or to the whole Executive Team. Issues identified by the Executive team will be cascaded to the appropriate committee/group. The/members of the Executive Team have responsibility for approving new corporate risks prior to uploading on the trust risk register. This will be done though single sign off or at the Integrated Performance Review Meetings.

4.9 Division/Clinical Unit Integrated Performance Meetings

These meetings provide the opportunity for each Division/Clinical Unit to share quality and performance qualitative and quantitative data and subsequent concerns and successes with the Executive Team. The core aim is to ensure each Division /Clinical Unit is aware of their quality and safety risks, performance and delivery risks and to provide assurance to the Executive Team quality improvement plans are in place and working to address issues.

4.10 Division/Clinical Unit Governance Meetings

The Governance meetings are for each Division/Clinical Unit to share issues, risks and learning from events with its team members and to establish actions to resolve them. This will provide the background information and discussion to the Integrated Performance Reviews. There are specific sections such as risks, incidents, complaints, mortality, and infection control to ensure the learning is discussed and shared.

4.11 Patient Safety and Quality Group

The Patient Safety and Quality Group has two key functions which are to:

- Provide a broad overview of Trust patient safety, patient experience and clinical effectiveness to identify trends and ensure findings are acted upon. This includes regular reviews of serious and amber incidents, other incidents, complaints, inquests and claims;
- To review and monitor the work plans and their progress for the senior groups/committees within the Quality and Safety Group itself. These are the Clinical Outcomes Group (includes mortality), Clinical Effectiveness Group, Infection Prevention Control Group, Medicines Optimisation Group, Safeguarding Group and the Health and Safety Group.

4.12 Improvement Sub Committee

The members of this group will initially to act as the ESHT 2020 Improvement Programme Board with the following main areas of responsibility:

- Ensure strategic projects have followed the Trust Business Case approval process with realistic benefit profiles and allocated funding
- Design, review and agree the programme governance, plans, approving the tranches, phasing and timescales between each phase
- Monitor the progress against the programme plan
- Ensure the programme is delivering the vision and raise concerns when that assurance is not perceived.
- Challenge unrealistic objectives and unmeasured activities

4.13 Corporate Functions – Team Meetings

Within Corporate Services there are specific teams such as Estates and Facilities, Finance, Human Resources, Assurance and Strategy and Operations. These teams will all hold monthly meetings where risks and quality improvements are included on the agenda. Sign off for new corporate risks will be by the Executive lead for the specific service. Concerns or issues to the organisation will be reported to the appropriate group/committee for action.

4.14 Relationships between Committees

In order to ensure a co-ordinated and holistic approach to the management of quality delivery and risk, there is cross membership between the committees detailed in the structures **(see Appendix A).** All the committees/groups are responsible for ensuring that risks in the area of responsibility are managed and reported (escalated) to their reporting committee/group as detailed in their terms of reference.

4.15 The Division / Clinical Unit Structure

For effective delivery of quality each Division/Clinical Unit must have a Governance Structure that manages delivery but also quality and risk as these ultimately drive performance. The specific structure for each is detailed in **Appendix B** of this strategy. There are and can be differences between the Divisions in their structure however all must ensure the following are robustly managed:

- Risk identification and management (risk register) – Review and update of current risks and identification and management of new risks;
- Incident management – Regular review of incidents for the division to identify trends and themes that can be addressed, and ensure investigations completed as per Trust policy;
- Serious and Moderate incident management – To ensure the investigations are completed on time and the duty of candour legislation is applied effectively. To share learning and complete actions identified to prevent re-occurrence;
- Complaints management - Review of trends and themes and appropriate management of dealing with complaints to ensure responses provided within the correct timeframe;
- Claims and Inquests – To be aware of these and ensure actions completed to prevent re-occurrence where failings identified;
- Mortality and morbidity reviews – To ensure all deaths are reviewed within the Trust policy timescales and learning and actions from cases are completed;
- Audit of effectiveness – To ensure compliance with national audit and best practice guidance and local audit completed with learning from all areas actioned;

- Workforce – to manage workforce in terms of recruitment, appraisals and training;
- Health and Safety (H&S) – To monitor H&S issues and incidents and act accordingly to provide a safe environment for staff, patients and visitors;
- Infection Prevention and Control – to monitor compliance with cleanliness standards and address learning from reported infections;
- Safeguarding (adults and children) – To ensure compliance with Trust policy;
- Monitor performance and quality – To use performance dashboards/measures and act on concerns. To monitor the Division/Clinical Unit Quality Dashboard and deep dive into wards /departments delivering poor or excellent performance and learn from these to support them and other areas;
- Quality Improvement - To identify quality improvement requirements (from all the above) and support teams in providing resources and monitoring delivery of these;

5. Duties of Key Individuals

5.1 Chief Executive

The Chief Executive has overall responsibility for ensuring that an effective risk management system and a system of internal control is in place within the Trust and for meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of Governance. As Accountable Officer, the Chief Executive is, through review of internal control systems, responsible for completing the Annual Governance Statement. The Chief Executive will ensure that the responsibilities for the management and co-ordination of quality delivery and risk are clear and that the structure outlined in this document is maintained.

5.2 Medical Director/Director of Nursing

The Medical Director and the Director of Nursing have delegated responsibility for ensuring and overseeing the implementation of appropriate governance systems which includes the development and maintenance of risk management and quality processes. They will provide the leadership to ensure the Trust undertakes this function in accordance with best practice, legal and statutory duties and will lead the Trust's approach on achieving compliance with standards relating to quality.

5.3 Director of Strategy

The Director of Strategy has delegated responsibility for leading the strategic direction for the organisation taking into account governance and risk management to ensure effective delivery against Trust business plan targets. This post will also be responsible for the improvement programme.

5.4 Director of Finance

The Director of Finance has delegated responsibility for ensuring the implementation of financial risk management and to seek and provide wherever possible available resources for quality improvement work within the Trust. This role has overall responsibility for the Project Management Office and Knowledge Management supported by the Associate Director of Knowledge Management and the Improvement Programme Manager. The Director of Finance is also the Senior Information Responsible Officer (SIRO) for the Trust.

5.5 Director of Corporate Affairs

The Director of Corporate Affairs leads on the development and management of the Board Assurance Framework and ensures that the organisation keeps abreast of best practice, legal and statutory requirements and national guidance.

5.6 Chief Operating Officer

The Chief Operating Officer is responsible for the safe operation of the services provided within the Trust ensuring staff and teams identify and manage risks effectively and deliver high quality care.

5.7 Non–Executive Directors (NED)

The role of the NED is to provide challenge and subsequent assurance to the quality of patient care and safety of staff and public through Board meetings, chairing of senior committees and conducting regular walk rounds within the organisation. The Non-Executive Directors should be sighted on all escalated concerns to safety and quality at Board level.

5.8 Associate Director of Governance

The Associate Director of Governance has overall responsibility to ensure the central governance team and functions are effective and supporting the Divisions/Clinical Units/Departments to deliver their quality and risk responsibilities. This includes supporting the Divisions and Clinical Units to have robust structures with a Trust wide framework in place to review and identify areas for improvement and to learn from successes.

5.9 Head of Governance

The Head of Governance is responsible for the central governance team which provides specialist support and advice on the implementation of the Risk Management. The central team will ensure there is support, advice and systems in place for incident management, risk management, clinical effectiveness, health and safety and patient experience. Specific roles from senior team members will be detailed within the relevant policies (e.g. Risk Management Policy and Procedure)

5.10 Division and Clinical Unit Leads, Heads of Nursing and Governance, General Managers and Senior Managers for Corporate Functions.

This staff group is critical for effective delivery of risk and quality improvement as they need to understand the systems in place and ensure fully embedded within their structure and teams. They must provide the resources within their areas to deliver on the core functions detailed in section 4.14 of this document.

5.11 All Managers

All levels of management must understand and implement this strategy and comply with Trust policies. They must ensure that adequate resources are made available to provide safe systems of work; this will include making provision for risk assessments, appropriate control measures, raising outstanding concerns, ensuring safe working procedures / practices and continued monitoring and revision of these. They will promote risk management and health and safety awareness among all staff by example and ensure that staff are appropriately trained and competent for assessing risks and determining adequate control measures within the working environment. They will support staff in identifying and delivering quality improvement work to continuously improve care, efficiency and eliminate harm.

All Managers are authorised to:

- Ensure that appropriate and effective risk management processes are in place within their area of responsibility and that all staff are aware of the risks within their working environment;
- Ensure all necessary risk assessments are carried out within their department;
- Implement and monitor any identified risk management control measures within their scope of responsibility;

- Review a summary of all incidents and risks within their teams and disseminating this information to ensure that appropriate learning takes place;
- Communicate risk management within their departments;
- Identify areas for improvement and work with teams to deliver these (internal and/or corporate teams).

5.12 All staff

All members of staff have an individual responsibility for the management of risk and quality and will:

- Be aware of and comply with the Trust's Risk Management Policy and Procedure;
- Accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that may be affected by the Trust's business;
- Comply with the Incident Reporting and Management Policy by reporting all types of incidents and near misses through the appropriate processes;
- Be responsible for attending any mandatory and relevant education and training events;
- Identify and raise areas in need of improvement to their line manager;
- Provide safe clinical practice in diagnosis and treatment
- Be aware of emergency procedures e.g. resuscitation, evacuation and fire precaution procedures appertaining to their particular division /unit location

6. Prevention of Harm

Prevention of harm requires an effective risk management and quality system to identify potential risks and act on them swiftly to mitigate or reduce the likelihood of the event happening or impact (consequence) should it occur. It also requires governance systems to be in place and followed such as policies and procedures, compliance with best practice and standards and recruiting and maintaining a skilled workforce.

6.1 Risk Approach, Identification and Register (Please refer to the Risk Management Policy and Procedure for process detail)

Definition of Risk Management:
Risk Management is the term applied to a logical and systematic method of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risks associated with any activity, function or process, in a way that will enable organisations to minimise losses and maximise opportunities. It is as much about identifying opportunities as avoiding or mitigating losses.

Definition of Risk:
Risk can be defined as 'the possibility of incurring misfortune or loss,' (Oxford English Dictionary) for example through an unexpected event happening that may either cause harm or have an impact upon patients, staff, visitors, partner organisations, strategic objectives, assets and/or reputation. In particular:

- Any element which has the potential to damage or threaten the achievement of the objectives, programmes or service delivery of the organisation,
- Anything that could damage the reputation of the organisation and undermine the public's confidence in it
- Failure to guard against impropriety, malpractice, waste or poor value for money
- Failure to comply with regulations such as those covering Health and Safety and the environment and the Care Quality Commission (CQC) fundamental standards.

- An inability to respond to or manage changed circumstances in a way that prevents or minimises adverse effects on the delivery of services.

Risk Assessment Process
The following steps must be taken when completing a risk assessment:

- Establish the context
- Risk identification
- Risk assessment
- Evaluation and Ranking
- Risk Treatment
- Monitor and review
- Communicate and Consult
- Escalation

Assessment Form/Scoring System
Once a risk has been identified it must be assessed and approved following the Risk Management Policy and Procedure available on the Trust intranet. The Risk assessment tool must be completed and approved prior to sending to the Trust Risk Team for uploading on the Datix system. Once approved it will be loaded onto the Datix or Assure system and will be live for review and sharing. Assessment and grading of risks is completed by using the National Patient Safety Agency (2008) framework as detailed in the Risk Management Policy and Procedure

Risks are approved, shared and communicated through the following systems:

Board Assurance Framework

- Risks to the achievement of trust Key Strategic Objectives
- Reported to: Trust Board, Quality & Safety Committee
- Stored: Executive Shared Folder

The Board Assurance Framework is a strategic risk management tool reporting key risks to the achievement of its aims and objectives. The Board Assurance Framework is used by the Trust Board to ensure that all identified risks are focused upon and that effective controls are in place thus providing assurance that a robust risk management system underpins the delivery of the organisation's principal aims and objectives. It highlights gaps in the effectiveness of controls or of assurance and informs the Board of the areas where it should be scrutinising the controls the organisation has in place to manage the principle risks.

Corporate Risk Register

- All Local risks 15 and above
- Reported to: Trust Board, Quality & Safety, Specific Groups/Committees, Divisions/Clinical Units
- Stored: Datix system

These risks are corporate in name due to the high level risk rating therefore there could be a significant threat to service delivery or safety for the organisation. The Corporate Risks receive more scrutiny and ensure members of the Trust Board are aware of them and have the opportunity to challenge the adequacy of controls in place and suitability of planned actions. These risks are stored on the Datix system and will remain as a permanent record

whether open or closed on the system. Sign off to approve these risks for a rating of 15 or above must be done by an Executive Director either at the Integrated Performance review or if a Corporate function through the Lead Executive for the department.

Local Risks

- All risks assigned to a specific department and or Division/Clinical Unit
- Reported/reviewed: Division/ Clinical Unit/Departments
- Stored: Datix system

These risks are Local in name because they are owned and managed by the departments and Divisions. They can originate directly from a Division/Clinical Unit or from a department working within it. These risks under 15 in rating will be managed, monitored, reviewed and shared within the Division/Clinical Unit structure. Should they require escalation following a review and re-grading they will become a corporate risk. All these Local risks are stored on the Datix system to allow ease of access and escalation. These include patient safety risk assessments such as opening new escalation areas

Generic Department Risks

- All local department risk assessments required for legislation such as lone worker, COSHH, Moving and Handling, Fire safety
- Reported/reviewed: Departments, Health and Safety Team, Health and safety Group
- Stored: Assure system

These are legislative risk assessments required to ensure compliance with the Health and Safety at Work Act 1974. They are generic assessments to ensure the safety and welfare of staff is well managed at department level. These are recorded on the ASSURE system and will only be escalated and recorded on the Datix system as Local or Corporate risks if there has been a number of incidents or an increased risk for the specific generic risk that cannot be managed by the department. The Generic Department Risk assessments are populated directly onto the ASSURE system and then approved by a manager before becoming live and available for review by other staff and teams.

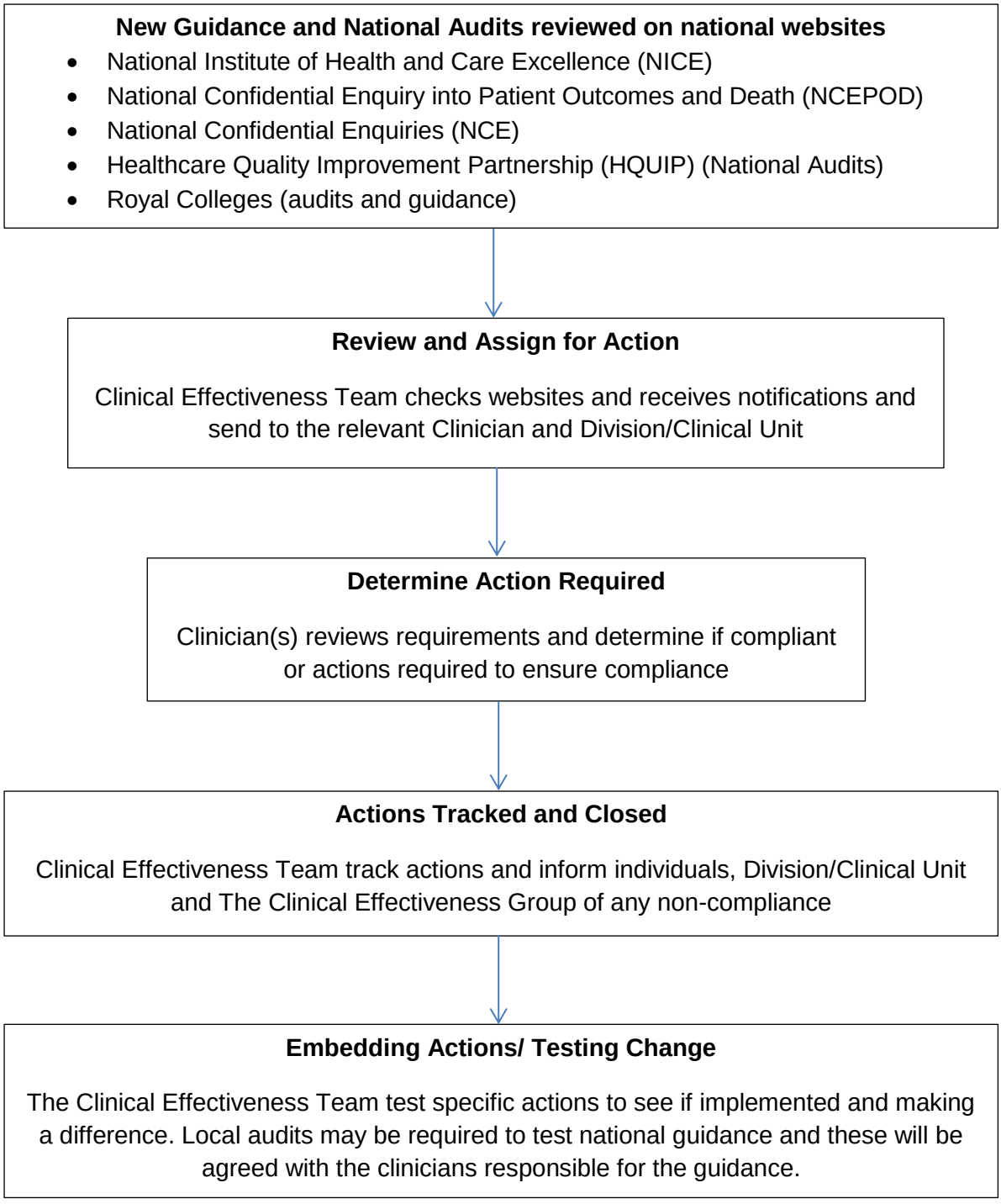
Monitoring and Reviewing Risks

All risks must be owned by the Division/Clinical Unit or Corporate Function and the Departments responsible. A lead manager is assigned to each risk to ensure it is reviewed on a monthly basis. Each Corporate risk is assigned to a responsible senior Group/Committee to ensure they are discussed and challenged in terms of their controls in place, rating and have appropriate actions assigned. Awareness of the risks and controls must be communicated to teams involved through Governance meetings, risk meetings and department team meetings.

The Governance Team manages the risk management software (Datix and ASSURE) to look for duplicated risks, trends and provide support to staff in completing and reviewing risks.

6.2 Compliance with national guidance and standards

National standards and guidance are usually an outcome from learning, audit and experience and therefore important for the Trust to recognise this and ensure recommendations are implemented to prevent harm to patients and improve the quality of care provided. The Clinical Effectiveness Team within the Governance Team structure identify new guidance and disseminate to the appropriate Clinicians and specialties for review and actions as detailed in the chart below:



The Clinical Effectiveness Group is responsible to monitor and respond to compliance with the process outlined above. Further information is within the Clinical Audit Policy and the Implementing National Guidance Policy

6.3 Staff skills, recruitment & training

To deliver quality care there must be a highly trained workforce who are positive about their work environment. The Trust recognises this and has in place through the Leadership and Culture Section a committee structure to deliver education, support and change programmes. The Education Steering Group which includes executive attendance from the Director of HR, Director of Nursing, and Medical Director ensures there are systems in place for the training and development of staff. There is a Corporate Human Resources (HR) Function with specific teams to manage the following:

- Learning & Development – manages the process for statutory and mandatory training, as well as other role essential, soft skills, and training. In conjunction with Clinical Education they also oversee the process of applying for funding for external training and development. In addition Workforce Development leads support the delivery of leadership and management development for staff.
- Clinical Education – Oversees the training and development for all clinical (non-medical) staff, including supporting students on placement, supporting newly qualified staff, and managing contracts with our partner Higher Education Institutes.
- Medical Education – Oversees the training and development of all Doctors in Training and some areas of development for Consultants and Staff Grade Doctors.
- Occupational Health - provides support to staff with health issues, and this department also includes Health & Wellbeing Co-Ordinators who look at ways of improving the health and wellbeing of our staff.

The Electronic Staff Record (ESR) system records training and staff details and regular reports are produced which detail compliance with statutory and mandatory training, and outline how we are spending education funding.
The HR department establish systems for appraisals and monitor compliance as described in the main Human resources Policies available through the trust extranet.

6.4 IT Systems

Information Technology Systems allow clinical teams to store and review data and flag up clinical concerns and findings. These are integral to patient safety and are in widespread use within the Trust and are tracked centrally on the information asset register managed by the Information Technology Department. There is a specific information governance manager in place to monitor and provide advice on Data Protection.

6.5 Policy Management

The existence and compliance with operational policies is crucial for ensuring there are safe and effective systems in place for the organisation as these are produced from best practice and national recommendations where identified. There is a Policy Management Group in place to sign off/approve the documents before they are uploaded onto the Policy Management System. The Policies are available through the trust Extranet and are tracked for expiry dates by the Governance Team. Each individual author and Division/Clinical Unit or Corporate Department is responsible for updating the documents when reminded of forthcoming expiry date.

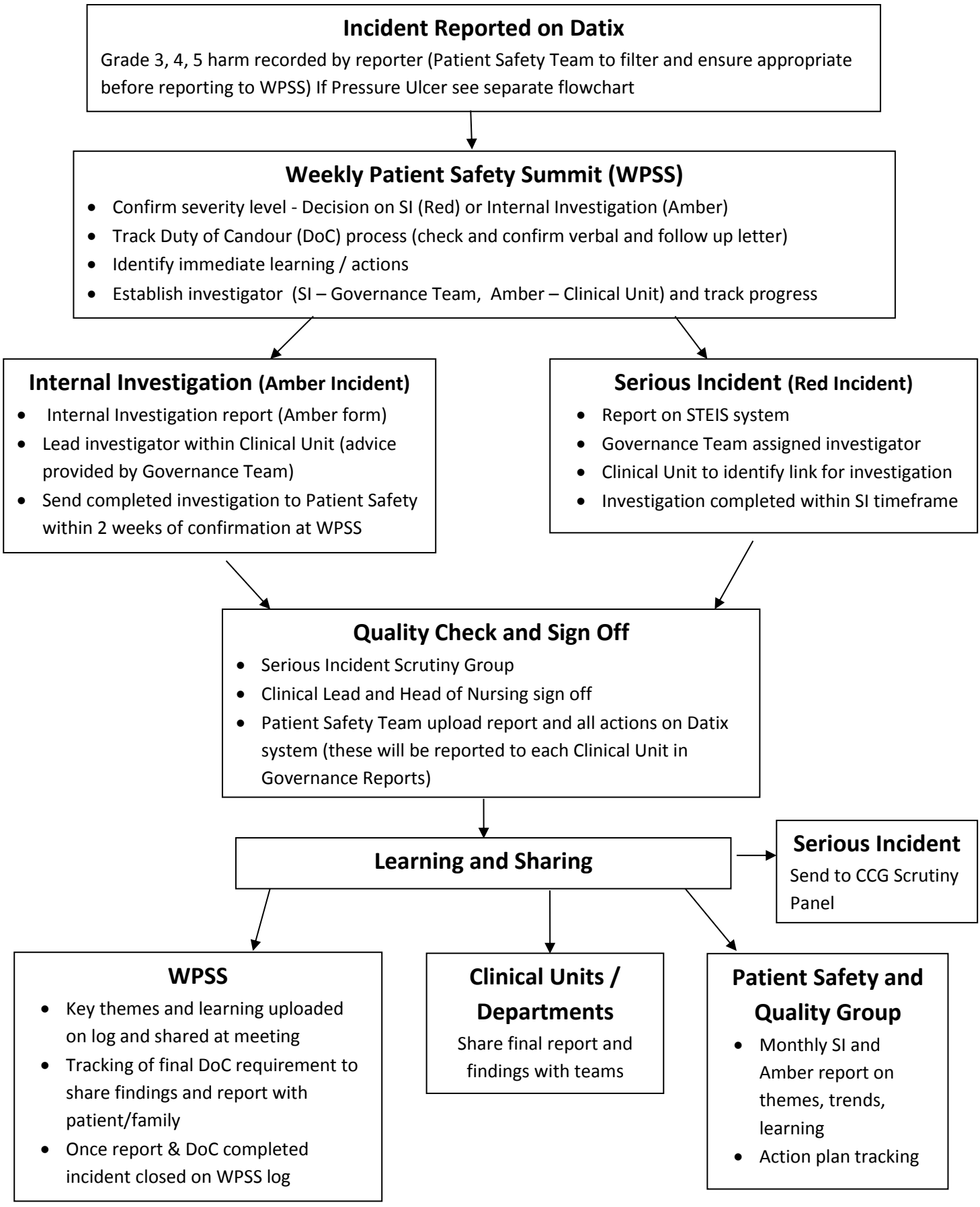
7. Learning from Experience

Learning from experience is generally achieved through incident investigations and patient feedback from complaints, user forums and questionnaires / surveys. Staff and department meetings, safety huddles and mortality reviews and audits can also provide learning opportunities along with other methods for individual and group learning. This section will focus on the processes in place for incidents, complaints, patient experience, mortality reviews, claims and inquests.

7.1 **Incident Management** (Please refer to the Incident Reporting and Management Policy for full details)

The central risk management system for the Trust is Datix which is used to record and store all reported incidents. Staff report the incident they have witnessed or were involved in directly onto the electronic system using the Datix incident form. There is a process from this point to track the incident and ensure it is managed and investigated as detailed in the Incident Reporting and Management Policy. Incidents are graded by severity at the point of reporting and then reviewed during the investigation process. All incidents with initial grading of 3 (moderate), 4 (major) and 5 (catastrophic) are reported to the Weekly Patient Safety Summit (WPSS) where a decision is made to confirm grading, declare and conduct a serious incident investigation, undertake an internal “Amber” investigation for moderate harm or downgrade and complete the standard investigation on Datix system. The process for this is outlined below:

Serious Incident (SI) and Moderate Incident Flowchart (grade 3, 4 and 5 severity)



The Serious incidents are investigated by members of the Governance team trained in Root cause Analysis to ensure the following:

- Independent review of the incident;
- Involvement of patient and or relatives in the investigation process;
- Ensure a high standard report using the same format;
- Independent discussions with people to ensure learning from all staff involved;
- Ensure effective compliance with the Duty of Candour;
- Increased support to the clinical teams saving them time away from patient contact.

An Amber (moderate) incident investigation is conducted when moderate harm has occurred however the event does not meet the NHS England criteria for reporting as a serious incident. This investigation will be robust and scrutinised centrally with the results shared with the patient and or family as part of the Duty of Candour process. An Amber investigation may also be conducted where the level of harm is unknown but the WPSS believe there are learning opportunities.

All Serious Incidents and Amber investigations are scrutinised at the Trust Serious Incident Scrutiny Group to provide assurance the investigation was robust and the key learning points have been identified. Once approved by this group as shown in the flowchart above the incident and findings can be shared with the teams involved and with the patient.

All other incident investigations are conducted by the allocated investigator and once completed are checked by the central Datix team and finally approved on the system. Once finally approved the specific incident feedback provided by the investigator is sent to the reporter of the incident electronically.

Learning from serious and amber incident reports is shared to members of the Serious Incident Scrutiny Group, Senior Leaders Forum and the Patient Safety and Quality Group to provide an overview of the organisation and ensure the event is not only known within the specialty or Division it occurred within. Each report is also shared and discussed at the Division/Clinical Unit Governance meeting where it must then be cascaded down to the relevant departments.

Learning and sharing all other incidents is achieved through the following methods:

- Individual feedback to the reporter;
- Discussion at department meetings;
- Discussion at Division/Clinical Unit Risk meetings and or their Governance Meetings;
- Incident analysis report for the whole trust reviewed at the Patient Safety and Quality Group (PSQG) on a monthly basis.

Specific trends identified by the Governance Team will be taken for discussion at the PSQG to determine the course of action. This could be to establish a task and finish group or to place under increase surveillance.

All required actions from serious and moderate incidents will be recorded on the Datix system and tracked for completion. This will provide assurance the organisation acts on findings from the incidents that can be tested to see if embedded in practice and effective.

Further detail on testing the learning from incidents is detailed in the monitoring and analysis in section 8 of this document.

7.2 Patient Feedback

Patient feedback is essential for any service to receive and action trends to improve the quality of care. This should always be encouraged whether positive or negative and the ethos must be to welcome any feedback.

The Patient Experience Steering Group is responsible for managing patient experience and providing the direction for the organisation. There will be 4 patient representatives on this group to provide feedback and challenge. The four key areas within the patient experience agenda are Friends and Family Test and patient questionnaires, complaints and patient advice and liaison service, volunteer support and patient information. The full process for managing complaints is detailed within the Managing Complaints Policy. There is a specific Complaints and Patient Advice and Liaison Service Team with all contacts formal and informal recorded on the Datix system. Formal complaints are responded to within the 35 or 45 day timeframe depending on the complexity and signed off by the Chief Executive. All actions the Trust will take stated in the response letter are recorded on the Datix system and tracked for compliance.

The Meridian system is the platform in place to record all the patient feedback from questionnaires and the Friends and Family Test. This enables the information to be shared with the departments and Divisions/Clinical Units. The Patient Experience Manager is responsible for recording and disseminating the information and the department managers are responsible for ensuring the information is collected within their department.

Trends and themes from patient experience must be identified and shared with the Divisions/Clinical Units. This will be achieved through the Patient Experience Team monthly report and deep dive on specific areas. The Patient Experience Steering Group will identify trends and feedback to the services providing the care requesting actions to be taken for improvement. Specific learning from complaints is shared at the Division/Clinical Unit Risk and or Governance meetings.

The Patient Engagement Team attends user forums and communicates to the wider community to seek feedback from the services delivered by the Trust.

7.3 Staff Engagement

A positive workforce is known to improve quality of care and services therefore staff feedback is essential to track this and act wherever possible to improve staff experience. The HR department has a Staff Engagement Team responsible for obtaining feedback and tracking improvement. This is in the form of forums, questionnaires and focus groups.

7.4 Inquests and Claims

Claims and Inquests are managed by the Trust Legal Department. The process for inquests is detailed below:

- Legal team informed of forthcoming inquest
- Legal team review the case and determine risk of claim and whether potential patient harm caused;
- If potential harm/risk identified the Legal team contact Patient Safety Team and ensure the details of the case and responsible Division/Clinical Unit are reported to the next Weekly Patient Safety Summit for discussion and agreed action. This could result in a Serious Incident or Amber investigation being conducted. The Patient Safety Team will check to determine if an incident has been recorded previously involving the patient;

- Investigation tracked as part of WPSS but managed by the Legal Team;
- Findings of report shared with Coroner on request (once report approved at serious Incident Scrutiny Group);

Claims Process below:

- Claim reviewed by Legal Team to determine if relating to patient safety;
- Where potential for patient safety concern Legal Team contact the Patient Safety Team who will check for related incidents/events on Datix system;
- If none reported will be identified at the next WPSS for discussion and confirmation of required action.

Learning from the inquest or claim will be included within the Division/Clinical Unit Governance Report and a summary report of all inquests and claims and lessons learnt will be reported to the Patient Safety and Quality Group on a monthly basis.

7.5 Mortality Reviews

Mortality reviews are crucial for identifying any lapse in care and or potential for learning and should be carried out in line with the Mortality and Morbidity Review Policy. There is a mortality database for recording and grading deaths to determine if expected or unexpected. The result of this will instigate review at specialty mortality review meetings. The Clinical Outcomes Group chaired by the Medical Director has specific responsibility to ensure there is a robust process for death reviews and learning. Feedback from these will be to the specialties attending the mortality reviews and to the members of the Clinical Outcomes Group who will share the findings across the organisation. Feedback and key issues identified will be reported to the Patient Safety and Quality Group. The actions identified from the mortality reviews are recorded on the database and tracked by the Clinical Outcomes Group for progress.

8. Monitoring, Analysis and Improvement

As described within this document there are systems in place for incidents, complaints, managing risks, inquests, patient feedback and staff feedback. The final part of the cycle is to make improvements to quality care and reduce risk of harm through learning from these events. This will be achieved through the following areas.

8.1 Clinical Audit

The Clinical Effectiveness Team manages the Trust clinical audit programme which includes the national audits as described earlier and also local audits. In addition there is the Meridian system that enables departments and the Trust to set up regular audit programmes for staff to enter results directly and receive reports on progress. For example this can be for compliance to falls risk assessments or Purpose T assessments for prevention of pressure ulcers. The Clinical Effectiveness Team is responsible for this system and ensuring all clinical audits are aligned to the Trust needs and areas identified in need of improvement. The results of these audits will be incorporated into the specific improvement programmes or task and finish groups to measure the impact of change and monitor performance. The

Clinical Effectiveness Group will receive reports on the overall clinical audit programme for the Trust.

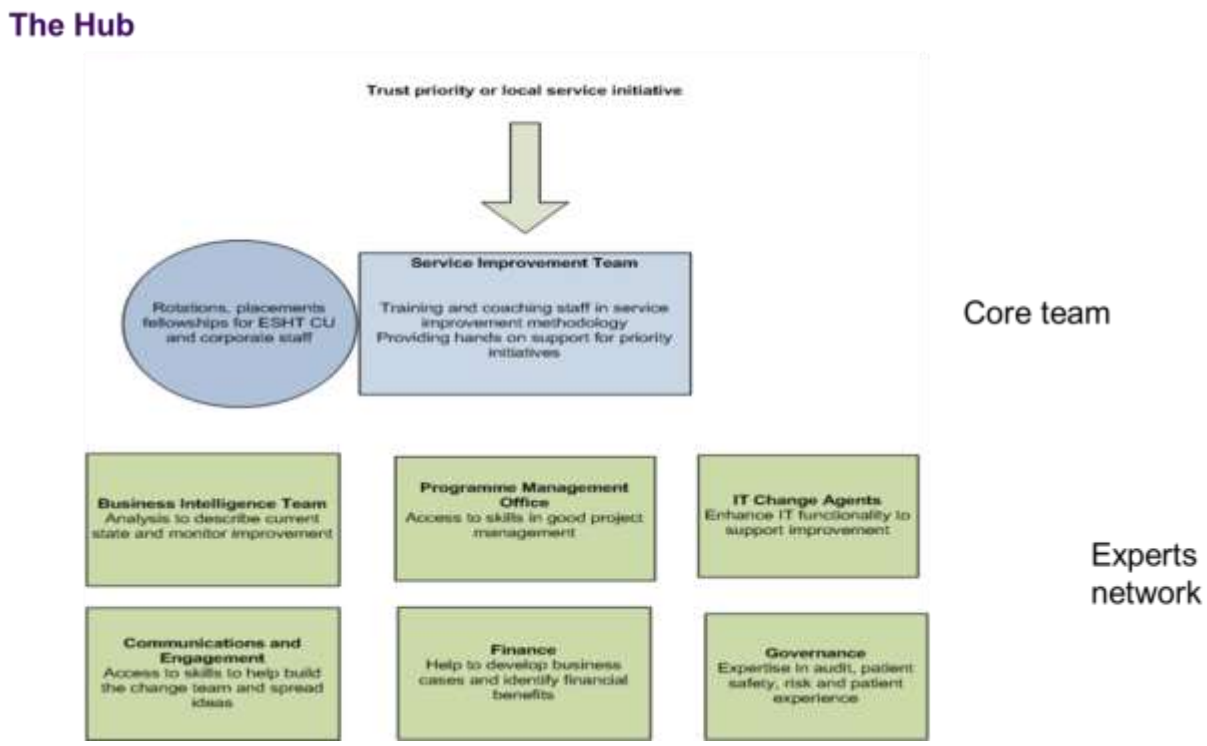
8.2 Testing Actions

Actions following Serious and Amber incidents and complaints are loaded onto the Datix system and tracked by Divisions/Clinical Units and core Groups such as the Patient Safety and Quality Group. The effectiveness of these actions and knowledge of whether they are making a difference are important to demonstrate changes, or to recognise if an ineffective response to a problem. The Clinical Effectiveness Team will select through guidance from the Patient Safety and Quality Group a theme each month and test to see if the actions have been completed and embedded into a service and are having a positive impact on change. The results of these will be reported to the Clinical Effectiveness Group and the patient Safety and Quality Group. The findings will also be fed back to staff in the relevant departments and also through the “Learning in Practice” newsletter.

8.3 Improvement

In most cases identified actions following incidents, inquests, claims and complaints can be completed by teams or individuals responsible for that service and can be achieved swiftly. This could be in the form of task and finish groups, some of which could have help from staff with improvement skills. As described in section 8.2 above they can be reported back to the departments to demonstrate what has been done or changed as a result and for trends and themes tested by the Clinical Effectiveness Team to determine if embedded in practice.

When a trend or particular safety concern has been identified that does not have an immediate fix or is a wicked problem in nature it will require input from experts in improvement methodology. These cases and issues will be identified through the Patient Safety and Quality Group (information fed through from sub groups), or Divisional Integrated Performance Reviews and decisions made to establish task and finish groups and or involve the service improvement hub. This as described below will consist of a core team of improvement experts utilising other expert teams within the organisation. The work load for this team and prioritisation of projects/improvement work will be guided by the Improvement Sub Committee to ensure there is control and awareness of all the improvement programmes and projects within the Trust. Prioritisation for these projects/improvement schemes can be achieved through a simple assessment of the risk and level of impact on quality care and positive financial return. Support to these schemes will also be provided through the Project Management Office and the Listening into Action Programme Team coordinated through the Improvement Sub Committee. The improvement hub will also offer opportunities to staff that will support a culture of continuous improvement within the organisation through coaching, training in specific improvement techniques and secondment opportunities.



8.4 Demonstrating improvement and sharing information

The Trust will share improvement programmes and schemes through the following schemes/documents:

- Quality Account – This document will describe the main quality account priorities for the year ahead and will provide a report on the achievements to the previous year priorities. This will also include the Sign up to Safety Campaign initiatives. Progress on these priorities is reported during the year to the Patient Safety and Quality Group. Clinical outcomes form various specialties will also be reported within this document.
- Commissioning for Quality and Innovation (CQUINs) – These are improvement schemes agreed with the Lead Clinical Commissioning Group that are linked to achievement payments. There is a CQUIN manager in place for the Trust reporting to the Associate Director of Knowledge Management. The schemes and progress towards them are reported to the Patient Safety and Quality Group.
- Reports to Trust Board, Quality and Safety Committee and other senior Groups – Comprehensive reports submitted to these committees and groups will include regular tracking of metrics such as the Integrated Performance Dashboard (includes the Quality Ward to Board Dashboard) and specific measure to track progress on work plans for the key groups. Reports are produced covering all aspects of quality to these groups.
- The Divisions/Clinical Units receive a Monthly Governance Report that details all aspects of governance such as risks, incident, mortality, complaints, inquests, patient experience from the previous month. A summary triangulating this information is provided within the main document to enable the department to see the key issues and to use as the escalation/summary to the Integrated Performance Reviews for each Division/Clinical Unit. These summaries are produced by members of the Governance team but can be supplemented further by the Head of Nursing/Clinical Leads as part of their analysis process.

- Each Group under the Safety and Quality Structure will have a work plan for the year set and tracked by the Patient Safety and Quality Group. These set the direction and priority of work required for each group to improve quality. The 2016/17 work plan is detailed within **Appendix C** below.

9. Annual Governance Statement

Each year the Board is required to produce an Annual Governance Statement which is signed off by the Chief Executive as the Accountable Officer. The Governance Statement records the stewardship of the organisation to supplement the accounts. The document outlines how successfully the organisation has coped with the challenges it faces and of how vulnerable the organisation's performance is or might be. This statement draws together position statements and evidence on governance, risk management and control, to provide a coherent and consistent reporting mechanism. The Board is required to provide evidence that the principle risks to achieving trust objectives have been identified and are being managed. As such the risk register supports the Assurance Framework in driving the Board agenda.

10. Equality and Human Rights Statement

An equality impact assessment has been carried out in order to establish that this policy does not discriminate or have a detrimental impact upon employees or service users on the grounds of disability, age, race, gender, sexual orientation, religion or belief. The issues to note are:

1. To ensure equal access to risk management staff training
2. To consider equality, discrimination and human rights related risks for inclusion on risk registers
3. To recognise the Equality and Human Rights Commission as an external inspector
4. To consider the Equality and Human Rights Analyses (EHRA) when assessing relevant risks

11. Copy Available

An electronic copy of this document is available on the Trust Intranet page under 'document search'.
Stakeholders can access a copy through the Trust website.

12. Strategy Review Arrangement

This Strategy is ratified by the Patient Safety and Quality Committee on behalf of the Trust Board and will be reviewed annually in order to ensure that it is current, relevant and reflects the strategic aims, objectives, organisational structures and responsibilities of the Trust.

13. Supporting and Related Documents

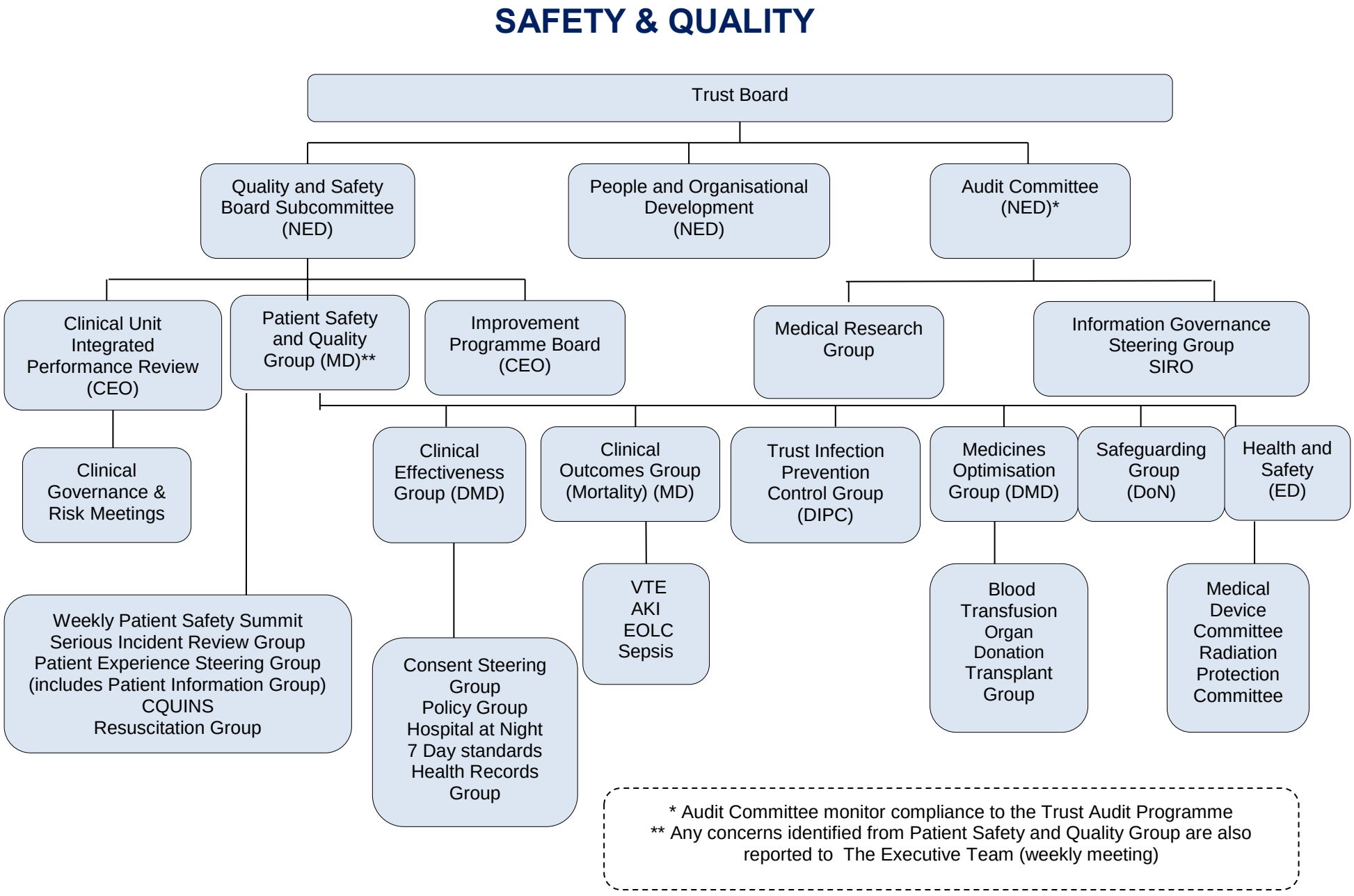
The Risk Management Strategy should be read in conjunction with:

ESHT Risk Assessment (General) Policy
ESHT Health and Safety Policy
ESHT Incident Reporting and Management Policy
ESHT Risk Management Policy and Procedure
ESHT Learning and Development Strategy and Policy
ESHT Mandatory Training Policy
ESHT Managing Complaints Policy

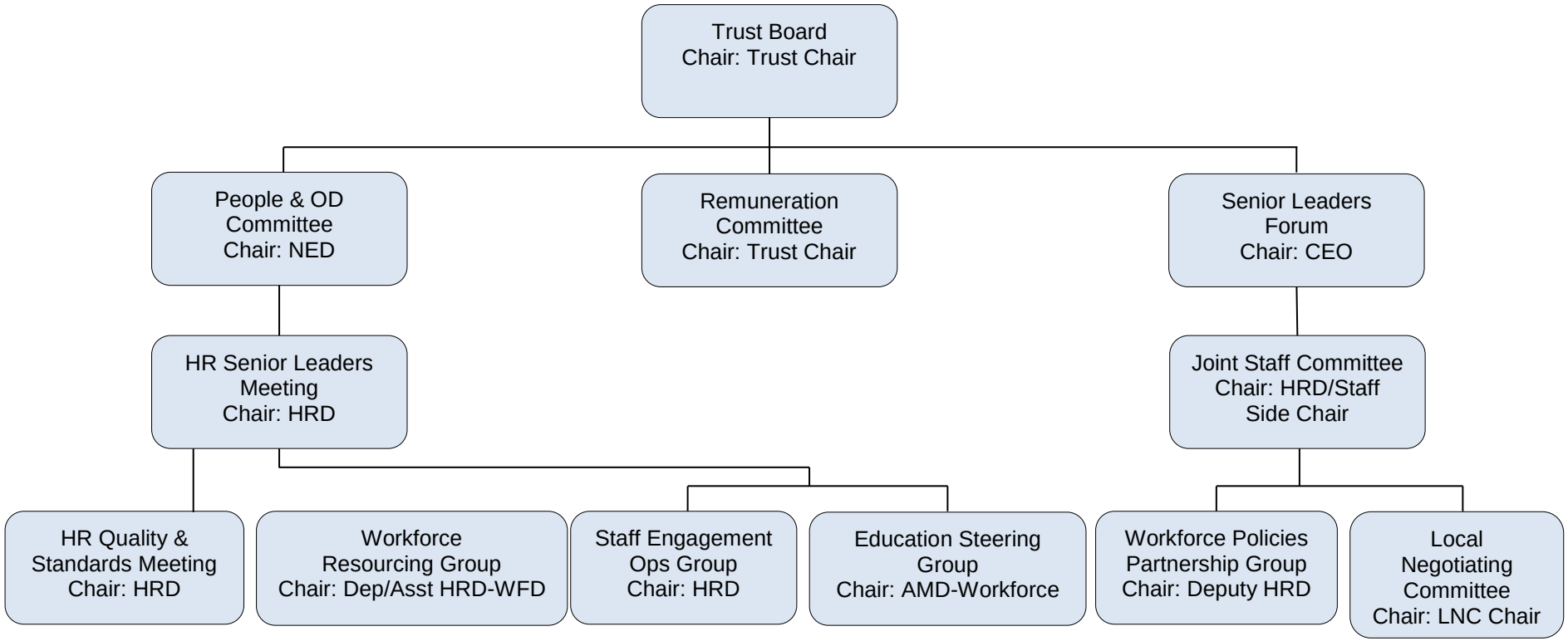
14. Useful References

Public Interest Disclosure Act 1998 (Department of Health circular HSC 1999/198)
NHSLA Risk Management Standards 2011/12
Health and Safety at Work Act 1974
Governance in the NHS (HSC2000/005) NHS Executive (February 2001)
Governance in the NHS Statement on Internal Control 2001/2002 and Beyond (including supplementary guidance) of 2002/2003 NHS Executive (March 2002)
NPSA 'Healthcare risk assessment made easy' (March 2007)
Australian Standard, Risk Management AS/NZS 4360:2004

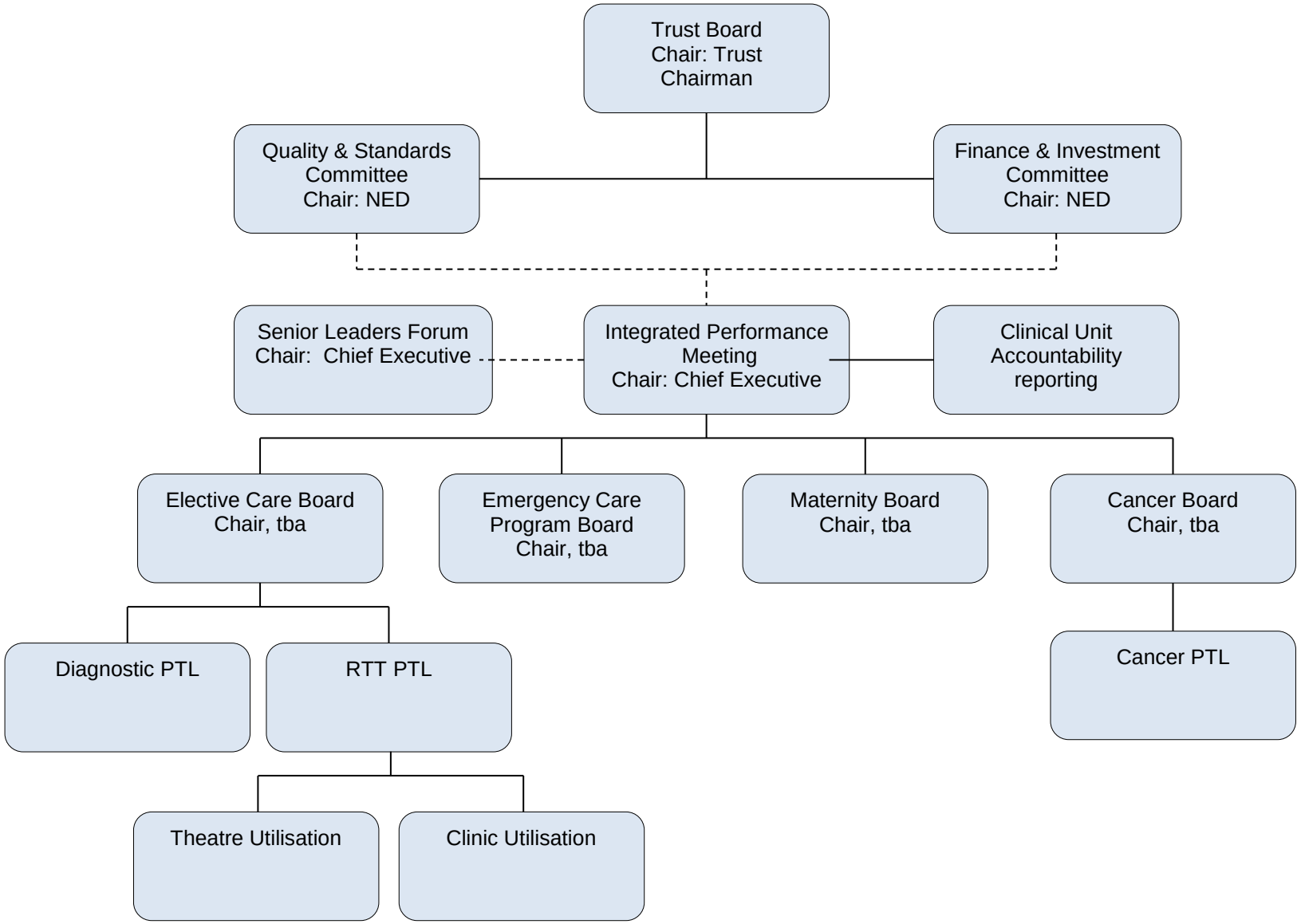
Appendix A - Committee/Group Structures



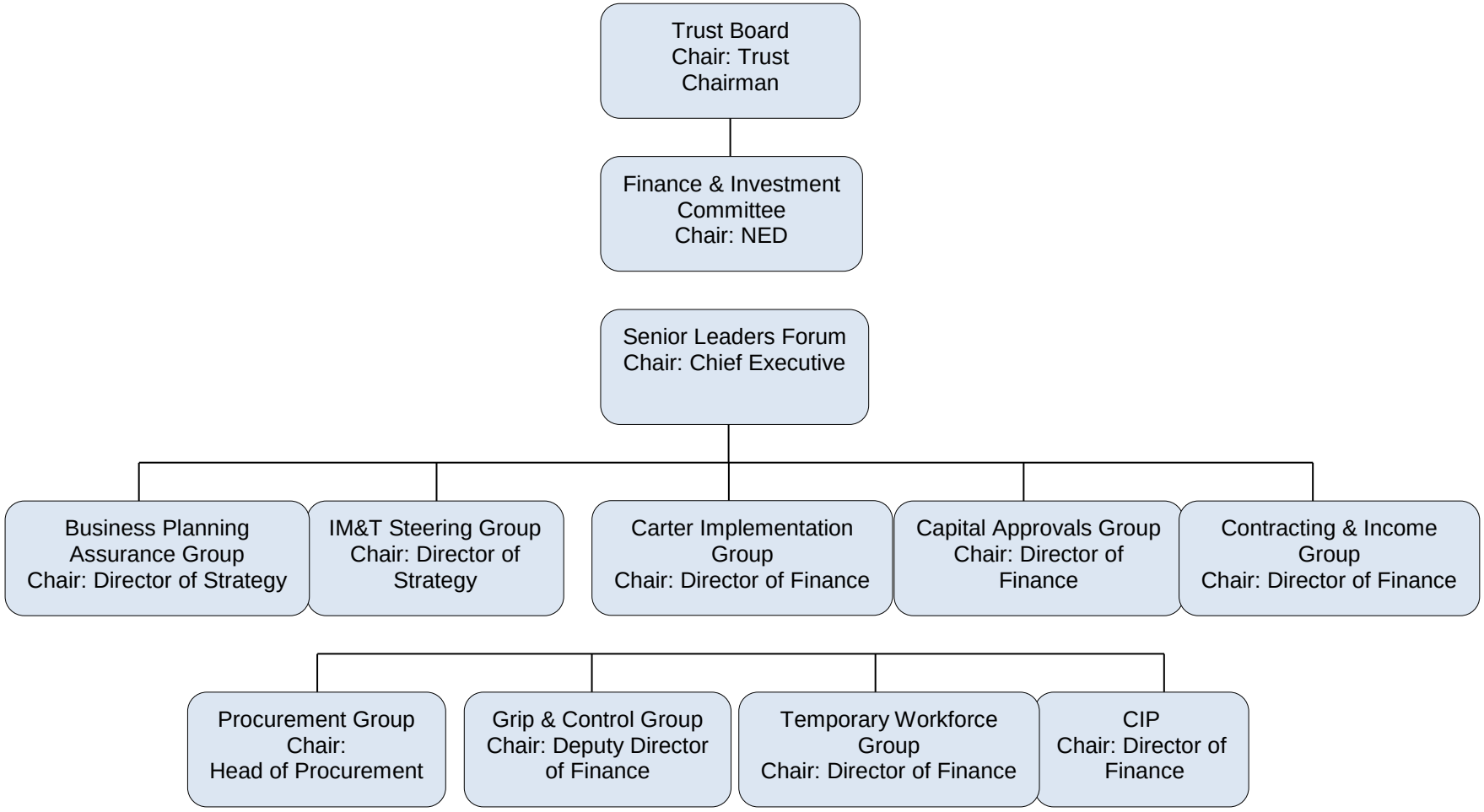
LEADERSHIP & CULTURE



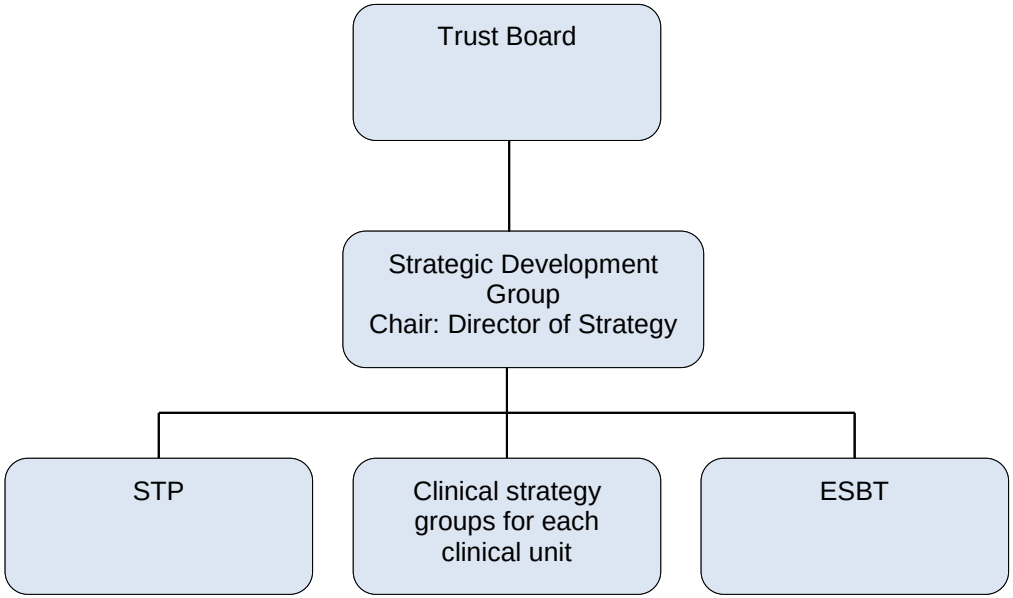
ACCESS & DELIVERY



FINANCE & CAPITAL

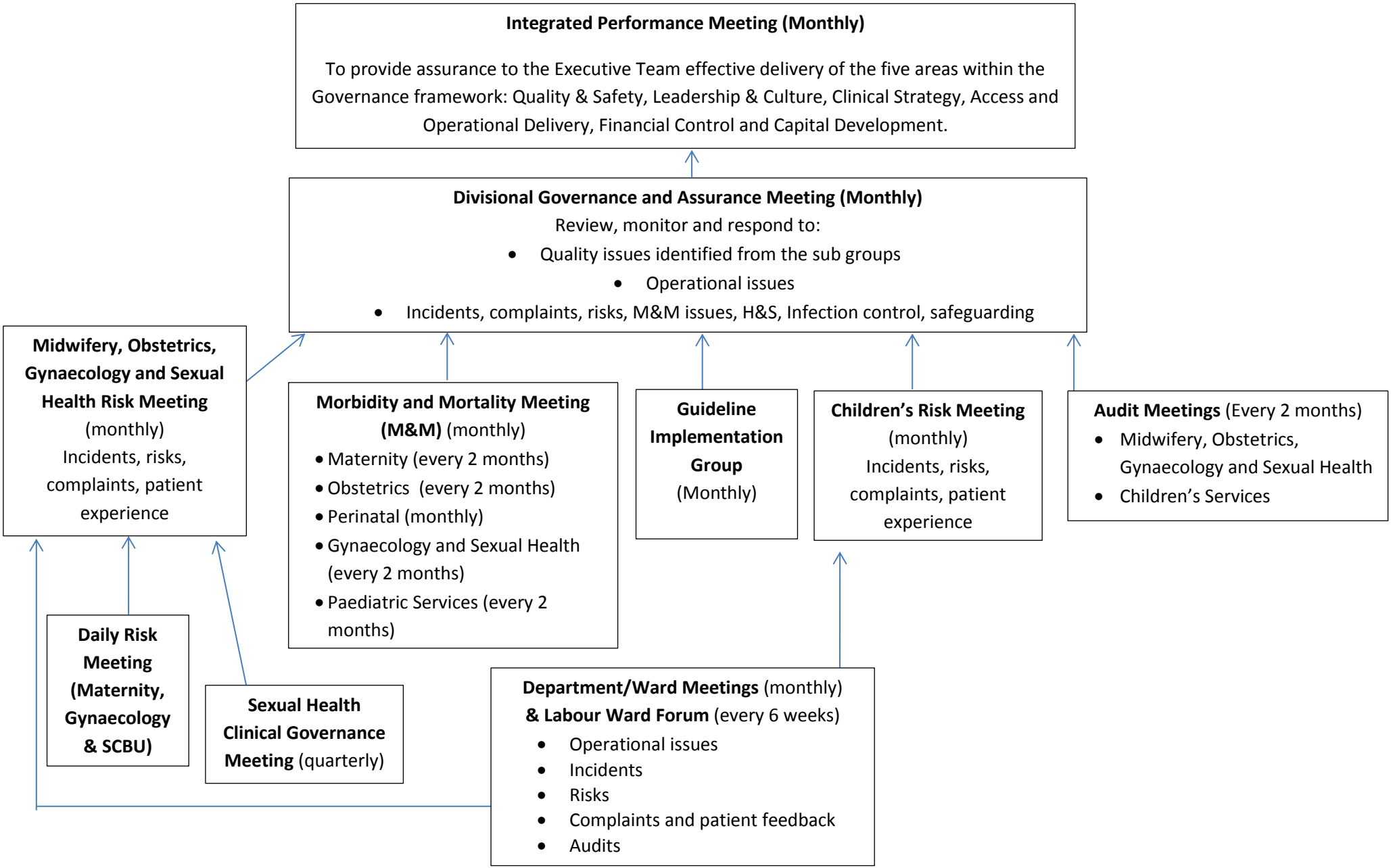


GOVERNANCE FOR STRATEGY



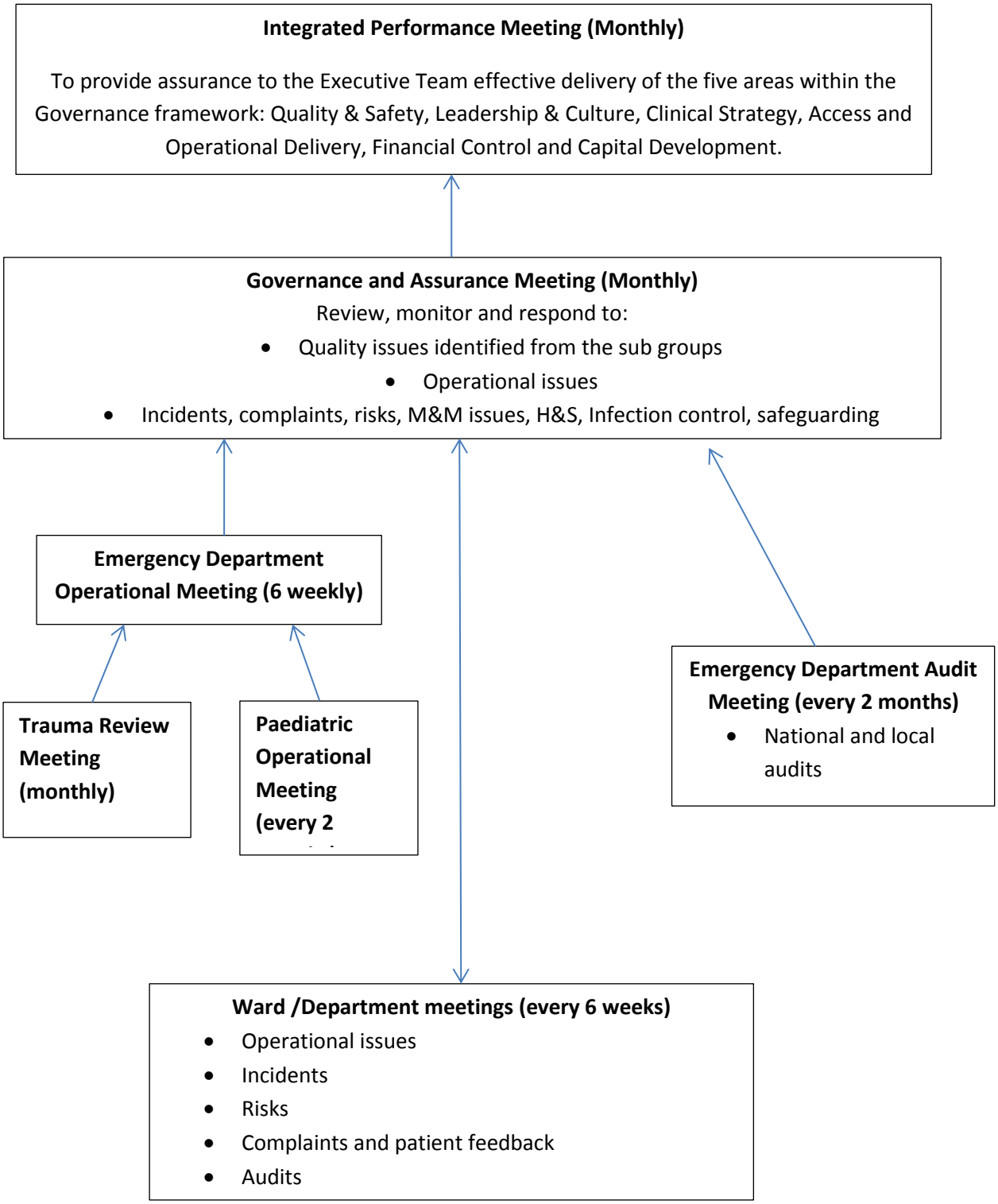
Appendix B – Division/Clinical Unit Governance Structures

Women Children and Sexual Health Division Governance Structure



Urgent Care Clinical Unit

Governance Structure



Out of Hospital Division

Integrated Performance Meeting (Monthly)

To provide assurance to the Executive Team effective delivery of the five areas within the Governance framework: Quality & Safety, Leadership & Culture, Clinical Strategy, Access and Operational Delivery, Financial Control and Capital Development.

Integrated Governance Meeting (Monthly)

(Includes Pharmacy)

Audit	Complaints
Risks	Performance
Incidents	Staffing
Patient feedback	Infection control
Safeguarding	Health & Safety

Department/Locality/Ward Meetings

- Operational issues
- Incidents
- Risks
- Complaints and patient feedback
- Audits

Surgery Anaesthetics and Diagnostics Division

Integrated Performance Meeting (Monthly)

To provide assurance to the Executive Team effective delivery of the five areas within the Governance framework: Quality & Safety, Leadership & Culture, Clinical Strategy, Access and Operational Delivery, Financial Control and Capital Development.

Divisional Quality Clinical Governance Meeting (Monthly)

Review, monitor and respond to:

- Quality issues identified from the sub groups
- Operational/Performance issues
- Incidents, complaints, risks, inquests/claims, H&S, M&M issues, Infection Control, safeguarding, quality improvement

Risk Meeting (Monthly) Anaesthetics/Critical Care/Theatres/IV Team/ Medical Illustration/Resuscitation/ Pain Team and Pre-Assessment

Risk Meeting (Monthly) Surgery (including Audiology, Trauma and Orthopaedics, Maxilla Facial)

Risk Meeting (Monthly) HSDU / Decontamination

Risk Meeting (Monthly) Pathology

Risk Meeting (Monthly) Radiology

Morbidity and Mortality Meeting (Monthly)

List all specialties here

WHO Surgical Safety Steering Group (every 2 months)

Health & Safety Link Meeting (every 3 months)

Ward /Department Meetings

- Operational issues
- Incidents
- Risks
- Complaints and patient feedback
- Audits

Clinical Audit Meeting (Every 2 Months)

List all specialties here

Medicine Division

Integrated Performance Meeting (Monthly)

To provide assurance to the Executive Team effective delivery of the five areas within the Governance framework: Quality & Safety, Leadership & Culture, Clinical Strategy, Access and Operational Delivery, Financial Control and Capital Development.

Divisional Quality Clinical Governance Meeting (Monthly)

Review, monitor and respond to:

- Quality issues identified from the sub groups
- Operational/Performance issues
- Incidents, complaints, risks, inquests/claims, H&S, M&M issues, Infection Control, safeguarding, quality improvement

Specialty Meeting (Monthly)

To cover all aspects within:

Quality and Safety, Leadership and culture, Clinical Strategy, Access and Operational Delivery, Financial Control and Capital Development

The following specialties will have meetings:

- Cardiology
- Respiratory
- Frailty
- Haematology
- Acute Medicine
- Stroke
- Dermatology
- Neurology
- Rheumatology
- Gastroenterology and Endoscopy
- Diabetes and endocrinology

Clinical Audit Meeting (Quarterly)

Cardiology
Stroke
Rheumatology,
Neurology &
Dermatology
Frailty
Haematology
Respiratory
Gastroenterology & Endoscopy
Diabetes and endocrinology

Ward /Department Meetings

- Operational issues
- Incidents
- Risks
- Complaints and patient feedback
- Audits

Morbidity and Mortality Meeting (Monthly)

Cardiology
Stroke
Rheumatology
Frailty
Haematology
Respiratory
Acute Medicine
Gastroenterology & Endoscopy
Diabetes and endocrinology

Appendix C – Work Plan – 2016/17

Quality and Safety Committee Structure Work Plan 2016/17

The Patient Safety and Quality Group (PSQG) will ensure each main group under the Quality and Safety Structure has a clear work plan aligned to the Patient Safety and Quality Strategy (incorporating ESHT 2020) that has key metrics in place to measure the progress and or outcome. The measurement of these will be reported to the Group for each meeting and should wherever possible be in a run chart format to enable effective improvement tracking. This document is a proposal of the priorities for each group for discussion at the September 2016 meeting. Each group reporting into PSQG has been asked to determine priorities that will need to be approved. Once priorities confirmed metrics will be determined. The safety and quality metrics detailed in the ESHT 2020 have all been incorporated in the metrics detailed below.

1. Patient Safety and Quality

1.1 Work plan

- Establish work plans for all main groups with improvement metrics in place for each (run charts);
- Establish robust governance system across all divisions/Clinical Unit supported centrally;
- Establish robust system to triangulate incidents, complaints and claims/inquests providing the ability to recognise and respond to areas of concern/trends (effective use of Datix reporting and analysis);
- Review and manage the Meridian Audit programme to provide a cohesive quality improvement measurement programme for departments;
- Develop a ward quality accreditation system based on data from quality dashboard, Meridian audit and quality visits (CREWS);
- Monitor patient experience through surveys, forums and mixed sex breach data and act on findings to inform change and improve experience survey results and complaint reduction;
- Ensure compliance with the Duty of Candour continues to improve;
- Produce and embed the floor to board quality dashboard;
- Embed the Serious Incident and Moderate incident investigation and learning process to produce timely, robust reports and act on findings;
- Continue with the patient fall task and finish group to reduce patient falls with harm;
- Reduce pressure ulcers grade 2 and above acquired whilst in trust care;
- Reduce patient transfers from ward to ward;
- Establish the complaints process, clear the backlog and act on findings and trends to reduce the overall number of formal complaints.

1.2 Metrics

Key outcome metrics to provide on a monthly basis in the form of a run chart to track improvements and identify where interventions made an impact:

- Number of complaints reported;
- Total number of open complaints in the system;
- Number of SI's reported;
- Patient falls with harm ;
- Pressure ulcers grade 2 and above;
- Mixed sex breaches;
- Duty of candour compliance with each stage;
- Outstanding amber incidents;
- Outstanding/overdue serious incidents;
- Number of transfers reported.

2. Medicines Optimisation Group

2.1 Work Plan

- Improving omitted and delayed medicines;
- Screening/ improving the quality of medication discharges;
- Improving medicines management and reconciliation;
- Antimicrobial Stewardship;
- Increased reporting and learning from medication incidents.

2.2 Metrics

Key outcome metric to provide on a monthly basis in the form of a run chart to track improvements and identify where interventions made an impact:

- Compliance with controlled drug checks;
- Compliance with medication reviews;
- Medication administration incidents;
- Medication Prescribing incidents;
- Controlled drug incidents.

3. Clinical Effectiveness Group

3.1 Work plan

- To ensure that a work plan for each reporting sub group is developed and in place for 2016/17 (to include Enhanced Recovery and Enhanced Quality)
- To monitor and ensure that the Trust participates in all required mandated national audits and acts upon findings appropriately, developing local action plans where required
- To monitor and ensure progress and full completion of local Trust audits and acts upon findings appropriately, producing full reports and developing local action plans where required
- Clinical record keeping standards – to ensure that a robust programme is in place to track and monitor compliance

- Consent - to track and monitor compliance with consent, and ensure 'SMART' actions are set to tackle areas of non-compliance
- To monitor and review the robustness of completed actions, ensuring that they have been effectively embedded across the Trust
- To highlight and effectively share lessons learnt and identified good practice as a result of Clinical Effectiveness activity widely across the Trust
- To progress with the 7 day care standards

3.2 Metrics

Key outcome metric to provide on a monthly basis in the form of a run chart to track improvements and identify where interventions made an impact:

- A number still to be determined for the work plan above.
- Number of patient safety incidents causing harm occurring during the night

4. Clinical Outcomes Group

4.1 Work Plan

- Conduct a complete review of the current mortality review process (includes database)
- Change and or improve the mortality review process (includes database)
- Ensure mortality drivers are reported to the Group and improvements in each area being made (sepsis, AKI, VTE)
- Monitor and achieve the End of Life Care strategy requirements
- Produce an overall document detailing outcome measures (such as PROMs and PREMs) for all specialties (work with Clinical Effectiveness Team)

4.2 Metrics

Key outcome metric to provide on a monthly basis in the form of a run chart to track improvements and identify where interventions made an impact:

- Reported Sepsis Cases per month
- Reported death/ITU admission from Sepsis per month
- AKI admission to ITU per month
- No of deaths relating to AKI per month
- Actual VTE reported cases per month
- No of deaths relating to VTE per month
- EOLC – Need to set something to track the strategy/plan
- Standardised mortality ratio per month
- No of Outcomes identified from each specialty across the trust per month (this is to track our progress on meeting and recording outcomes available for the first year to then identify gaps and determine how to track and share data in future)

5. Infection Prevention and Control Group – To be confirmed (although there is a comprehensive action plan in place)

6. Safeguarding Group – To be confirmed

7. Health and Safety Group – To be confirmed

These will be developed and in place by the end of October 16.