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North Cumbria University Hospitals NHS
NHS Trust

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Governance, Risk Management & Quality Strategy 2011 - 2013

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Approved policies related to this policy

Name Policy
Maternity Risk Management Strategy
Risk Assessment Policy
Management of External Visits Policy
Incident Management Policy

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Version	Date	Changes / comments received from
0.1	03/05/2010	Rewritten to combine Risk & Governance Strategies
0.2	22/06/2010	Comments received from Company Secretary
0.3	23/06/2010	Comments from Head of Governance & Quality & Co Secretary
0.4	23/06/2010	Comments from Director of Nursing, Quality & Governance
0.5	24/06/2010	Formatted by Head of Corporate Affairs
0.6	29/06/2010	Amended following Trust Board Development Day
0.7	01/07/2010	Final review and amendments by Company Secretary
0.8	09/07/2010	Final draft following Board approval on 06/07/2010
0.9	10/01/2011	Amended to incorporate the new NHSLA Standards 2011/12 and CQC Essential Standards of Safety and Quality
0.10	01/02/2011	Strategy updated to reflect new risk management process
Final	08/02/2011	Final version for publication APPROVED BY THE TRUST BOARD 08/02/2011
1.0	19/12/2011	Strategy updated and reviewed as part of annual review of strategy for Governance Committee approval December 2011
1.1	09/01/2012	Final strategy updated for Trust Board ratification January 2012

SUMMARY

This document provides the overarching framework for governance, risk and quality within the Trust. It identifies key responsibilities for all staff and describes how the organisation will assure itself that business is operating within an appropriate regulatory framework, and that risks to patients, staff and the organisation are managed effectively.

This document also sets out the essential standards of quality and safety as set out by the Care Quality Commission.

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1. INTRODUCTION

Our overriding strategic aim as an organisation is to ensure we provide high quality, safe and effective services for all our patients. It is the responsibility of every employee of North Cumbria University Hospital NHS Trust (the Trust) to understand the principles set out in this strategy and what this means for their day to day duties in providing care to patients.

Our Trust recognises that governance and risk management in the NHS is evolving constantly. It is committed to continuously improving its processes, in line with key national guidance and best practice to ensure safe, high quality care for our patients. In addition it is committed to the provision of a clear framework within which our staff can work effectively.

As part of reviewing and strengthening our governance arrangements, the Trust has reviewed the key recommendations from the Francis Independent Inquiry Report 2010. This has included reviewing governance in practice whilst also assessing how governance is embedded across our Trust.

This strategy describes the roles and responsibilities of all staff as well as outlining the framework for the holistic management and assurance of governance, risk and quality.

Our Trust recognises that implementing this strategy at all levels across the organisation will require developing shared attitudes, values, goals and practices that characterises our organisational culture. In addition the Trust believes that the active promotion and development of an open, fair blame and just culture will facilitate this process. Creation of an open and fair safety culture requires staff at all levels of the organisation to be committed to risk management within their own sphere of work.

Our Trust is committed to a holistic approach to governance and risk management by taking those steps that are feasible to minimise the harmful effects of loss on the organisation – either loss of service quality, loss of a safe environment for staff, financial loss or loss of reputation.

This document should be read in conjunction with the maternity Risk Management Strategy and any operational policies that are referred to throughout the document where appropriate.

2. PURPOSE OF THIS STRATEGY

This strategy outlines the Trust's arrangements for Governance, Risk Management and Quality in order to ensure that the systems and processes that we have in place provide safe care for our patients. This includes defining the overall framework to ensure we are a well governed organisation.

3. DEFINITION OF TERMS USED /ABBREVIATIONS

Governance, risk management and quality have evolved and developed significantly during recent years, including within our own organisation. Therefore, it is important to ensure we have a common understanding of language used to describe governance, risk management and quality:

3.1 Governance

Governance is - 'Systems, processes and behaviours by which organisations lead, direct and control their functions in order to achieve organisational objectives, safety and quality of services and in which they relate to patients and carers, our staff, the wider community and our partner organisations'.

3.2 Risk Management

Risk management is 'the term applied to the use of a logical and systematic method of identifying, analysing, evaluating, controlling, monitoring and communicating risks associated with any activity, process or function necessary to the achievement of the organisation's objectives'.

Risk management is a continuous process and it aims to influence behaviour and develop an organisational culture within which risks are recognised and addressed.

3.3 Quality

Quality is the delivery of safe, effective care which results in a positive patient experience.

Further definitions included in this strategy can be found in Appendix 1

4. SCOPE

This strategy and the management arrangements detailed is to be followed by all staff, volunteers, agency workers, bank staff and contractors engaged on Trust premises and on Trust business.

5. OUR ORGANISATIONAL VALUES

As an organisation, we recognised that our values and behaviours are central to how we embed governance, risk management and quality in all our activities and day to day responsibilities.

Our values are to:

Embed quality and safety at the heart of everything we do

To achieve this we will;

- Treat our patients the public and each other with honesty and openness
- Promote and protect each individual's right to be treated with dignity and respect
- Measure and continuously improve the standards of safety and quality delivered to our patients
- Provide a safe and clean environment that promotes patients' comfort and well-being
- Support and develop our staff to deliver and achieve the best possible standards of care
- Measure and improve the experience of our patients and our staff
- Be polite, courteous and non-judgemental in our communication and engagement with each other
- Be caring, compassionate and kind to others

Deliver excellence at every turn

To achieve this we will;

- Ensure we use our resources in the most efficient way
- Strive to get the basics right, first time, every time
- Practice efficient and effective team working by committing to achieving common goals in every team and department
- Encourage involvement and ownership
- Use evidence, best practice and innovation to develop our services for the future
- Learn from our mistakes
- Celebrate and encourage excellence across our organisation and build pride in our reputation
- Be responsible and accountable for our own and collective actions

6. DUTIES AND RESPONSIBILITIES

Statutory Responsibilities

6.1 Trust Board and Director Responsibilities

The Trust Board is responsible and accountable for ensuring that effective governance and risk management systems are in place to support the safe delivery of care to patients as well as ensuring a safe working environment for all staff.

The Chief Executive has on behalf of the Trust Board, responsibility for maintaining a sound system of internal control. This requires the organisation to have in place the necessary controls to manage its risk exposure. Through the Trust Board, Audit Committee, Governance & Quality Committee and Divisional Boards, the Chief Executive is assured that effective leadership for Governance and Risk Management is provided and that the strategic objectives are met.

Each Executive Director and Director is responsible for ensuring that their individual obligations for effective governance and risk management are achieved and implemented within their areas of responsibility. This includes leading the reinforcement of the organisational values and goals that determine our culture.

The Trust Board is responsible for ensuring that effective information and reporting structures exist to ensure scrutiny on key governance and risk issues, which contribute to the standards of safety and quality across the organisation.

This includes receiving:

- Monthly exception report on key governance issues, incorporating on a quarterly basis the key issues arising from the Divisional Governance Reports for that quarter
- Quarterly report on Integrated Strategic Risk Register and Assurance Framework
- Six monthly review of the status of the Trust's objectives
- Formal minutes from the key committees of the Board as detailed in Appendix 2.
- Report on compliance with Care Quality Commission Registration
- Internal Audit Review of the Trust's Governance and Risk arrangements as part of the Statement of Internal Control.

Responsibility for the day-to-day management of risk is devolved locally to the Business Units, Divisions and Corporate Departments, which are tasked with the responsibility to lead the co-ordination, integration, oversight and support of the risk management agenda through the Trust's Governance Structure.

6.2 All Employees Responsibilities

All members of staff have a legal responsibility for working within Health and Safety legislation, including meeting their job description requirements for Risk Management by:

- Ensuring they embrace and promote our organisational values.
- Understanding and working in accordance with all Trust policies and procedures.
- Attending induction.
- Attending mandatory annual update training on Risk Management, Health and Safety or by completing the annual H&S workbook.
- Identification and immediate reporting of identified risks.
- Identification and reporting untoward incidents / near misses.
- Participate in annual appraisal and KSF review.
- Identification of own training needs and agreeing these with managers.
- Safe use and maintenance of equipment provided for health and safety of self or others.
- Be aware of all relevant emergency procedures.

Additionally, all members of clinical staff have a responsibility to:

- Practice within the standards of their professional bodies, other national standards, and any locally determined clinical policies and guidelines to ensure their practice is as risk free as possible.
- Provide incident reports and supporting documentation for any unexpected event or incident arising from clinical care or treatment provided.

All job descriptions contain information about Risk Management Responsibility and Accountability. Line Managers must further clarify specific responsibilities at local induction and within job plans where relevant and ensure these are regularly reviewed as part of individual appraisal and objective setting.

6.3 Ward and Head of Department Managers Responsibilities

Post holders have authority to manage risks at local level that do not have a specialty wide, Divisional or Corporate impact and will:

- Actively implement this Strategy in their areas of responsibility.
- Ensure Risk Management systems and processes are in place and are implemented to reduce risk to its lowest practicable level.
- Ensure that all staff attends annual mandatory Training or that they complete the workbook, as appropriate.
- Raise risk awareness in the department.
- Seek risk and safety advice as appropriate.

- Ensure incident reporting, management and investigation and ensure that lessons are learnt and shared.
- Escalate risks that cannot be managed locally to the relevant senior management Team.
- Escalate all risks having a Speciality, Divisional or Corporate impact to the Matron or Professional Head for discussion and appropriate management.
- Ensure all staff complies with this Strategy and associated procedures.
- Ensure that Governance, Risk and Quality management is an integral part of appraisal and staff development.
- Supply the Governance Facilitator with information for his/her monthly reports.
- Monitor action plans and report by exception to the governance facilitator.

6.4 Divisions (Local Risk Management) Responsibilities

Each Division has a number of Business Units, wards and departments that will provide assurance to the Divisional Management Boards that:

- Untoward incidents and near misses are reported by all wards, departments and staff groups;
- Untoward incidents and near misses are investigated appropriately
- All risks are adequately identified, entered onto the appropriate ward or department Risk Register via the Ulysses system
- All risk registers are reviewed, updated and monitored within the agreed timescales
- Ensure this strategy and the core pillars of governance are embraced and developed within their Division.

Through the Associate Medical Directors and Divisional General Managers, Divisions are required to assure the Governance & Quality Committee that:

- Local arrangements are established and implemented in accordance with the principles and objectives set out in this Strategy, ensuring that each ward and department has a local risk register captured within the Ulysses system.
- The core pillars of governance defined in this strategy are implemented, monitored and reported on as part of the management of their Division.
- The Divisional Board reviews the governance arrangements within each of the business units to ensure there is an effective structure from the ward/clinical department levels to the Divisional Management Team.
- The Divisional Risk Register is updated and reviewed monthly by the Division.
- Incidents and near misses are reported and immediately investigated or escalated.
- All serious untoward incidents (SUIs) are appropriately escalated.
- SUI investigations are conducted according to the agreed timescale required by NHS Cumbria.

- Any actions arising from SUI investigations are completed within the required timescales.
- Local aggregated analysis takes place relating to data provided from incidents, complaints and claims reports.
- Actions plans and lessons learned are implemented following complaints and incidents and are reported through the Divisional Board.
- Effective systems are in place to ensure the ongoing development and review of individual staff and clinical teams.

All Executive Directors, Directors, members of the Divisional Boards and all those staff with managerial and supervisory responsibility, will have risk management responsibilities defined in their job descriptions.

Each Division has a named Governance Lead who has the responsibility to facilitate the co-ordination of risk management and risk education within the division. Each divisional governance lead will contribute rotationally to corporate risk management activities and training.

All managers across the Trust have a responsibility to encourage staff to identify risks and to ensure that they are familiar with this strategy, the latest risk management policies, guidance and controls. Risk registers will capture formally the assessment and management of each risk identified at local level.

6.5 Divisional Governance Facilitator

- Provide leadership and support for the development, implementation and monitoring of risk management within the division (in conjunction with the Divisional General Manager).
- With the Divisional Professional Head, co-ordinate, develop and drive the governance process for the management of incidents.
- Provide support to all members of the divisional team with regard to management of risk, complaints, and claims.
- Develop and maintain the divisional risk register (via Ulysses) and report to the divisional management board.
- Provide a written report to each Divisional Management Board meeting
- Facilitate the co-ordination of risk management and risk education within the Division.

6.6 Medical Director (MD)

- Recognised Responsible Officer (RO) for the Trust.
- Responsibility for ensuring effective systems and processes are in place to support the delivery of safe quality care (jointly with DoN).
- Responsibility for ensuring effective clinical governance arrangements are in place (jointly with the DoN).
- Responsibility for ensuring that necessary arrangements are in place for the Caldicott Guardian role for the Trust.
- Responsibility for ensuring the pillars of governance are embraced and implemented across the organisation (jointly with DoN).

- Advise the Trust Board on any issues relating to clinical governance.

6.7 Director of Nursing & Quality (DoN)

- Executive lead for infection prevention and control (DIPC).
- Executive Director with responsibility for Clinical Governance including Risk Management for acute and maternity services.
- Responsibility for ensuring effective systems and processes are in place to support the delivery of safe quality care (jointly with MD).
- Responsibility for ensuring the pillars of governance are embraced and implemented across the organisation (jointly with MD).
- Responsibility for ensuring effective clinical governance processes are in place (jointly with the MD).
- Ensure that Serious Untoward Incidents are managed, investigated and lessons learned where necessary.
- Ensure the provision of risk and governance related reports to the Trust Board.
- Report to the Board on all relevant Risk Management Standards
- Report to the Board on all compliance and regulatory items, including the Care Quality Commission requirements.
- Ensure Risks are monitored on the Integrated Risk Register and Assurance Framework
- Joint delegated named “submitter” for the Care Quality Commission registration requirements (jointly with Director of Operations)
- Advise the Trust Board on any issues relating to clinical governance.

6.8 Director of Operations

- Ensure that the Divisions have in place effective Governance and Risk Management arrangements in accordance with the framework set out in this strategy.
- Joint delegated named “submitter” for the Care Quality Commission registration requirements (jointly with the Director of Nursing and Quality).
- Ensure a co-ordinated approach is taken on key compliance and performance returns in conjunction with the Director of Nursing and Quality.
- Ensure that the Monthly Divisional Business Reviews contribute to effective governance and performance monitoring in accordance with the core pillars of governance set out in this strategy.
- Ensure that this Strategy is embedded within the clinical divisions.

6.9 Director of Finance / Deputy Chief Executive Responsibilities

- To ensure the strategic development and operational management of the Trust’s financial control, and the assurance of that system
- Ensure that the Trust carries out its business of providing healthcare within sound financial governance arrangements.
- Ensure that financial governance is controlled and monitored through robust audit and accounting mechanisms that are open to public scrutiny on an annual basis.

- Ensure that the Trust has an effective internal audit service to support the organisations governance and risk management arrangements.
- Seek the Chief Internal Auditor's Opinion on the effectiveness of Internal Financial Control.
- Ensure there is a system for all incidents of physical assault against members of staff are reported to the Counter Fraud and Security Management Service (CFSMS).
- Ensure the Trust complies with Secretary of State's Directions relating to counter fraud activity in the NHS.
- Nominated Director for Information Governance and Information management related risks, including Senior Information Risk Owner.

6.10 Director of Human Resources and Organisational Development

- Ensure that effective HR systems and processes are in place to support robust workforce governance, including statutory requirements for example nursing and Midwifery Council registration.
- Report on workforce planning and development to the Trust Board.
- Ensure the provision and implementation of an integrated Education and Training Prospectus, inclusive of Risk Management Education and Training.

6.11 Director of Governance & Company Secretary

- Ensure that the Board has in place effective systems and processes for governance and risk management (jointly with Executive Directors).
- Oversee the Trust's governance and risk framework in conjunction with the Medical Director and Director of Nursing and Quality.
- Lead on the delivery of this strategy and associated objectives, including the management and leadership of the governance team.
- Ensure the compliance arrangements for CQC and NHSLA are implemented effectively and reported to the Trust Board.
- Ensure the supporting Committee Structure of the Board is effective and reviewed on an annual basis, including the monitoring of annual committee work plans to ensure delivery of their terms of reference.
- Maintain and review the Trust's Integrated Risk and Assurance Framework in conjunction with the Head of Patient Safety and Clinical Governance and provide a quarterly report to the Trust Board.
- Ensure issues of compliance and regulatory requirements are reported and reviewed by the appropriate sub committee and Trust Board.
- Seek the Chief Internal Auditor's Opinion on the effectiveness of the Assurance Framework and the Annual Statement of Internal Control.
- Ensure our stakeholders, for example Local Involvement Networks and the Health and Wellbeing Overview and Scrutiny Committee are regularly updated and informed on the quality and standards of care delivered to the local population.

6.12 Director of Estates and Facilities

- Ensure an effective Estates Management Strategy and associated policies and procedures are in place
- Ensure effective monitoring and joint working with PFI partners.

6.13 Head of Patient Safety and Clinical Governance

- Lead on specific patient safety and clinical governance programmes of work to support delivery of this strategy and improving the overall quality and safety of care given to patients.
- Provide support and advice to the divisions with regard to this strategy.
- Ensure the operational risk registers and monitoring process is robust in the clinical divisions.
- Support the governance facilitators within the divisions to drive up standards of patient safety & risk enabling them to deliver the work streams required to implement this strategy, with a primary focus on clinical risk reduction, quality patient outcomes and education.
- Ensure external reporting of Serious Untoward Incidents on StEIS.
- Lead and manage the NHSLA Assessment Processes.
- Ensure adequate information is provided to new staff at induction on how the organisation is governed, including the management of risk.
- Monitor action plans in relation to specific patient safety issues/projects.

6.15 Health & Safety Manager /Local Security Management Specialist

- Management lead for the Health and Safety Committee.
- Provide advice and support to all staff on Health and Safety matters including risk assessments.
- Implement the Health & Safety Executive's Risk Management Standards.
- Provide a Health and Safety training programme.
- Review, analyse and report on H&S related untoward incidents and near misses.
- Local security management specialist.
- Support the
- Fire Officer.

6.16 Local Counter Fraud Specialist

- Perform fraud risk assessments as requested.
- Raise awareness throughout the Trust of the risk of potential fraud risk and advise on suitable counter measures.
- Regular reporting on fraud risk and counter fraud work plan progress to the Board via the Audit Committee.
- All other activities in connection with counter fraud work including investigation in accordance with secretary of state's directions.

6.17 Patient Relations Manager

- Manage the complaints process with the divisional governance leads.
- Provide complaints management training throughout the Trust.
- Be a key member of the Complaints, Incidents and Claims Review Group.
- Identifying and sharing lessons learnt from complaints throughout the Trust as appropriate
- Provide analyses of complaints trends to enable aggregated analyses with untoward incidents to take place
- Identify, assess and escalate all risks arising from complaints.

6.18 Litigation Manager Responsibilities

- Co-ordinating the management and investigation of claims.
- Providing claims management training.
- Identifying and reporting on claims to Governance and Quality Committee quarterly.
- Be a key member of the Complaints, Incidents and Claims Review Group.
- Identifying and sharing lessons learnt from Claims throughout the Trust as appropriate.
- Provide analyses of claims trends to enable aggregated analyses with untoward incidents to take place.

6.19 Head of Clinical/Emergency Planning/ Equality & Diversity

- Mitigation and escalation of risks associated with emergency planning.
- Coordinating the development of all necessary emergency contingency plans to ensure preparedness for an effective response to any major incident, pandemic or emergency
- Ensure that the organisation fully recovers to normal services as quickly as possible
- Ensure that the Trust has a detailed Major Incident Plan (MIP), which is tested and reviewed at least on an annual basis to manage major adverse incidents and disasters impacting on NHS services.
- Ensure that the plans address effective communications with patients, relatives, carers, management, emergency, services, specialist advisors, Inspectorates, press, media and the public.
- Management Lead for the Emergency Preparedness Steering Group.
- Ensure a training plan is implemented with regard to emergency planning issues.
- Ensure that the Emergency Preparedness Steering Group develops an implementation and monitoring process for business continuity planning issues within the organisation.

7. HOW OUR ORGANISATION IS GOVERNED

7.1 Our Organisation has six Core Pillars of Governance:

7.1.1 Compliance and Regulation

This is the conforming to agreed standards through the various regulatory bodies that all NHS organisations have to comply with for example NHSLA, CQC, CNST, HSE. The outcomes from external agency visits as well as meeting the required national and local performance indicators is also included in our compliance with key standards and regulations.

7.1.2 Standards, Safety & Experience

These are the three core strands for how we measure quality within our organisation:

- The **Standards** of care we set for our patients and staff and how we monitor and benchmark against best practice and other organisations.
- The **Safety** of the care we provide to our patients and the Safety of the environment we provide for our staff to work in.
- The **Experience's** our patients have from the care we give and the Experience's our staff have in their day to day working environment.

7.1.3 Risk Management

This is the process within the organisation for the management of all clinical and non-clinical risks. This includes the management of incidents, near misses, and ongoing assessment of risks in clinical and non clinical areas across the organisation.

7.1.4 Workforce Governance

This is the system to ensure all staff are safe and supported to deliver quality patient care. This includes the collective accountability to ensure fair and effective management arrangements exist for all staff as well as how we develop our staff to meet the objectives of our organisation.

7.1.5 Information Governance

This ensures necessary safeguards for, and appropriate use of, patient and personal information.

7.1.6 Financial Governance

This is the process by which the finances and our financial plans for the organisation are monitored and reviewed. A key component of this is ensuring all staff follow the Trust's Standing Financial Instructions and Scheme of Delegation.

7.2 Reporting and monitoring framework

The Trust has in place a committee structure, which supports the effective governance and risk management of the organisation (see appendix 2). The key committees of the organisation have an agreed annual programme of work to ensure the delivery of their terms of reference (copies of the terms of reference can be accessed via appendix 3). The divisional reporting structure is a key strand of our reporting and monitoring framework from 'Ward to Board'.

7.2.1 Governance and Quality Committee

This is the Committee of the Trust Board with the responsibility for gaining assurance in relation to risk controls for clinical and non-clinical risks, governance and quality. This 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 clinical Divisions will report quarterly to this committee on the key issues in relation to the six core pillars of governance.

Equal emphasis is placed on the monitoring of quality outcomes arising from the clinical Divisions as well as the key supporting committees, which report directly to the Governance and Quality Committee

- Clinical Standards Sub Group
- Health and Safety Committee
- The Learning Development Group
- Emergency Preparedness Steering Group
- Equality and Diversity Steering Group

- Safeguarding Board
- Information Governance Steering Group
- Trust Policy Group
- Healthcare Records Committee
- Infection, Prevention and Control Committee
- Drugs and Therapeutics Committee
- Compliance Steering Group

The Governance and Quality Committee will also receive minutes of meetings from other meetings for information, for example the Trust Partnership Forum to ensure connectivity on issues that cross over into patient care, risk management or supporting workers.

The Committee meets a minimum of ten times/year and the responsibilities are described in the terms of reference in Appendix 3.

7.2.2 Audit Committee

This Committee is a statutory Committee of the Trust Board and has the responsibility for reviewing the establishment and maintenance of an effective system of internal control across the whole organisation's activities. It is also responsible for ensuring that the system supports the achievement of organisational objectives.

The Audit Committee provides independent scrutiny on the systems and processes the organisation has in place to meet its objectives and ensure a robust system of internal control exists.

The Audit Committee monitors and reviews the actions arising from internal and external audits and ensures an annual audit plan is in place.

The Audit Committee reports to the Trust Board through formal minutes of the meeting.

7.2.3 Charitable Funds Committee

This Committee is another statutory committee of the Board, which is established in accordance with the Trust's role as a corporate trustee for funds held in trust, either as charitable or non charitable funds, the Trust Board will administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

7.2.4 Remuneration Committee

The purpose of the Committee is to advise the Trust Board on appropriate remuneration and terms of service for the Chief Executive and other Directors including:

- all aspects of salary (including any performance-related elements/bonuses);
- provisions for other benefits, including pensions and cars;
- arrangements for termination of employment and other contractual terms.

7.2.5 Other Committees (Strategy and Delivery)

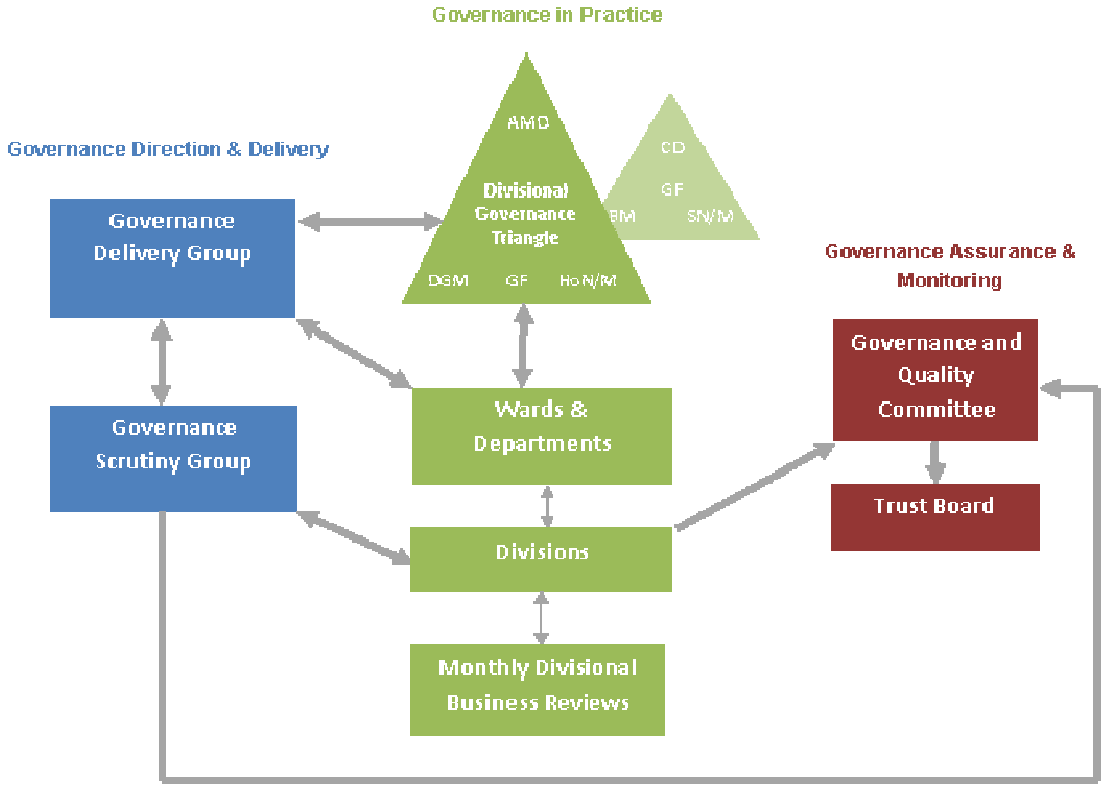
The Trust Board also has operational delivery and strategic delivery committees as part of its overall committee structure which are listed in Appendix 2. This includes:

- Senior Management Team
- New Hospital Project Board
- Finance, Performance and Workforce Committee

Terms of reference for the above can be obtained in appendix 3.

7.3 Governance in Practice

In addition to the Trust's committee structure the Trust also has effective systems and structures within the clinical Divisions to support the delivery of this strategy and robust governance in practice.



AMD = Associate Medical Director, HoN = Head of Nursing/Head of Midwifery, DGM = Divisional General Manager, GF = Governance Facilitator, CD= Clinical Director, BM = Business Manager, SN/M = Senior Nurse/Midwife

7.3.1 Governance Direction and Delivery

The Governance Delivery Group (terms of reference for this group can be accessed via appendix 3), consists of:

- The Director of Nursing and Quality
- The Medical Director
- Director of Governance and Company Secretary
- The Head of Patient Safety and Clinical Governance
- The Head of Midwifery and risk midwife as necessary
- The Governance Facilitators
- The Information Governance Officer

The main remit of this group is to ensure that there is weekly review and escalation in place for all incidents and complaints within the Trust.

This group is also responsible for reviewing the preliminary information regarding high level incidents.

This group also monitors and authorises the closure of high levels incidents, following investigation to ensure improvements are made and lessons are learnt.

7.3.2 Governance Scrutiny Group

The Governance Scrutiny Group consists of the Director of Nursing & Quality Medical Director, Director of Governance & Company Secretary and Head of Patient Safety and Clinical Governance. The main remit of this group is to scrutinise on a weekly basis the key outputs from the Governance Delivery Group as well as discussing any other significant governance issues that arise within the organisation.

This group also reviews and makes recommendations to the Chief Executive regarding the declaration of Serious Untoward Incidents.

Any key issues are reported from this group into the Executive Management Team (EMT) and Senior Management Team (SMT) where appropriate on a weekly basis.

The outputs of the Governance Scrutiny Group in relation to declaring an SUI are reported to the Trust Board on a monthly basis.

The Governance Scrutiny Group also invites representatives to the meeting before closure of high level incidents or to discuss issues in greater detail, where necessary.

7.3.3 Governance in practice

Within each Division there is a Governance Triangle that consists of the Associate Medical Director, Divisional General Manager and Head of Nursing/Lead Professional. The main responsibility of the Governance Triangle is to operationally manage and review all aspects of governance and risk management for their Division. The Governance Facilitator is part of the Governance Triangle and facilitates the operational management and development of Governance across the clinical areas.

It is important to highlight that the large Divisions also have business directorates which will have a sub governance triangle consisting of the Clinical Director, Business Manager and Senior Nurse/Midwife or Matron.

The Trust has in place quarterly divisional business reviews which as well as focussing on performance it is also an opportunity to discuss key quality and safety issues affecting. Divisions report into these review meetings via a reporting template.

7.3.3 Divisional Management Boards

Each division has in place a Management Board, which reviews the 'six core pillars' of governance at each meeting. This ensures that the core components of governance are joined up and aligned to this strategy.

7.3.4 Governance Assurance and Monitoring

Each quarter representatives from the Divisional Management Team will report issues relating to the core pillars of Governance via a reporting template to the Governance and Quality Committee. The Governance and Quality Committee review specific divisional issues as well as join up any common themes on the risk, quality or governance across the organisation.

Following these quarterly reports, key issues from the Divisions are reported to the Trust Board each quarter in the monthly governance report.

The financial governance pillar of governance is reviewed with the monthly business reviews, Senior Management Team and the Finance, Performance and Workforce Committee.

7.4 Internal Audit

This provides an opinion on the governance and assurance processes, including the opinion on the adequacy of the Assurance Framework, the risk management arrangements and the maintenance of CQC registration. The Audit Committee will receive the internal Auditor's annual review. Action plans to address the recommendations will be monitored by the Audit Committee at each meeting.

7.5 External Audit

The Audit Commission are an independent group of professionals who advise us throughout the year and perform a year end audit on our financial statements. In addition, the External Auditors also carry out specific reviews in other aspects of the Trust's governance systems, for example production of the Quality Account.

8. QUALITY OF CARE

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England. All providers have to be registered for the services they provide and therefore licensed in meeting essential standards of quality and safety which the CQC monitors on a regular basis.

The Trust applied for registration with the CQC and was granted full registration without conditions from 1 April 2010. In order to maintain this registration the Trust has developed steering group to monitor the ongoing collection of evidence to maintain that registration.

The Director of Governance & Company Secretary chairs this group and reports to Governance & Quality Committee on progress and by exception as required.

The Trust Board also receive a quarterly report on compliance with the CQC regulations and outcomes.

Care Quality Commission Essential Standards of Quality and Safety

1. You can expect to be involved and told what's happening at every stage of your care

- You will always be involved in discussions about your care and treatment, and your privacy and dignity will be respected by all staff.
- You will be given opportunities, encouragement and support to promote your independence.
- You will be able to agree or reject any type of examination, care, treatment or support before you receive it.

2. You can expect care, treatment and support that meets your needs

- Your personal needs will be assessed to make sure you get care that is safe and supports your rights.
- You will get the food and drink you need to meet your dietary needs.
- You will get safe and co-ordinated care where more than one care provider is involved or if you are moved between services.

3. You can expect to be safe

- You will be protected from abuse or the risk of abuse, and staff will respect your human rights.
- You will be cared for in a clean environment where you are protected from infection.
- You will get the medicines you need, when you need them, and in a safe way.
- You will be cared for in a safe and accessible place that will help you as you recover.
- You will not be harmed by unsafe or unsuitable equipment.

4. You can expect to be cared for by qualified staff

- Your health and welfare needs are met by staff who are properly qualified.
- There will always be enough members of staff available to keep you safe and meet your health and welfare needs.
- You will be looked after by staff who are well managed and have the chance to develop and improve their skills.

5. You can expect your care provider to constantly check the quality of its services

- Your care provider will continuously monitor the quality of its services to make sure you are safe.
- If you, or someone acting on your behalf makes a complaint, you will be listened to and it will be acted upon properly.
- Your personal records, including medical records, will be accurate and kept safe and confidential.

The services, treatment and care provided to the population of North Cumbria must be safe, effective and sustainable. Treatment and care is based on the best available evidence of interventions that work and is delivered by competent and qualified staff.

The Trust promotes a culture whereby staff are able to acknowledge mistakes, take action to put things right and learn from the event. Staff are encouraged and have a responsibility to report adverse events, near misses, concerns and unexpected outcomes. The Trust promotes a culture of “being open” and “fair blame”. The Incident Management Policy details the information for this.

The sharing of learning is a fundamental element of patient safety management, and by integrating risk management into all activities, promoting reporting, having open communication with patients and their families when things go wrong, the Trust can demonstrate and share learning. By the implementation of changes in practice or the instigation of solutions to prevent further harm the Trust can learn and improve.

One of our five strategic aims is 'to ensure we provide high quality, safe, effective services'. All NHS organisations are required to publish an annual Quality Account, which is both a reflective account on the standards of quality of care delivered during the previous year as well as a forward plan as to the quality priorities that will be delivered in the following year. For 2010/11 our quality priorities are captured within our Quality Account which is reviewed and published annually. The national quality priorities, including the NHS outcomes frameworks also forms part of the organisations quality priorities.

8.1 Safety

8.1.1 Monitoring Patient Safety

Patient Safety is monitored through the following routes:

- Evidence against Care Quality Commission Essential Standards of Safety and Quality.
- Specific quality and safety indicators included in the monthly performance report – i.e. infection prevention and control.
- Mortality and morbidity review process within Divisions through the CHKS system.
- Incident management and risk assessment.
- Divisions report quarterly to the Governance & Quality Committee and must include evidence that clearly demonstrates their effective management of patient safety and clinical risk.
- The key divisional issues are shared and reported at the Governance & Quality Committee including learning from incidents, claims and complaints.
- The Director of Governance includes information and trends in relation to incidents, complaints and claims in the monthly report to the Trust Board.

8.1.2 Standards for Patient Safety

To ensure that patients receive treatment and care that is as safe as possible and of a high quality; the Trust will comply with the NHS Litigation Authority (NHSLA) and Clinical Negligence Scheme for Trusts (CNST) and the requirements of CQC registration on meeting the essential standards of safety and quality. In addition the Trust has in place a system to ensure the Trust responds to the National Patient Safety Agency (NPSA) alerts and never events.

8.2 Effectiveness

Clinical effectiveness is the extent to which specific clinical interventions do what they are intended to do, i.e maintain and improve the health of patients securing the greatest possible health gain from the available resources. This includes clinical audit, benchmarking and evidence based practice which form a key component of the Trust's patient safety framework.

8.3 Experience

The importance of ensuring patient and public involvement, including being responsive and sensitive to the needs and wishes of patients, their families and carers is a fundamental aspect of measuring the quality of care we deliver to patients.

The Trust has in place various methods to capture the experience of patients. This includes the use of real time patient feedback and also ensures we learn lessons across the organisation from complaints and incidents.

The Trust has patient panels in place to ensure key issues regarding patient experience and services are discussed and reviewed. Patient panel members are instrumental in the completion of real time patient experience questionnaires.

The Trust also links into the various specific patient support groups on relevant issues. The Trust's communication and engagement strategy sets out how the engagement and experience of patients will be developed during 2011/14.

The Trust takes part in the national patient survey as well as specific specialty focussed surveys for example cancer services.

9. THE RISK MANAGEMENT PROCESS

This is the term applied within the NHS for the application of a logical and systematic method of identifying, analysing, evaluating controlling, monitoring and communicating the risks associated with any activity, process or function necessary for the achievement of the organisation's objectives.

North Cumbria University Hospitals NHS Trust is committed to:

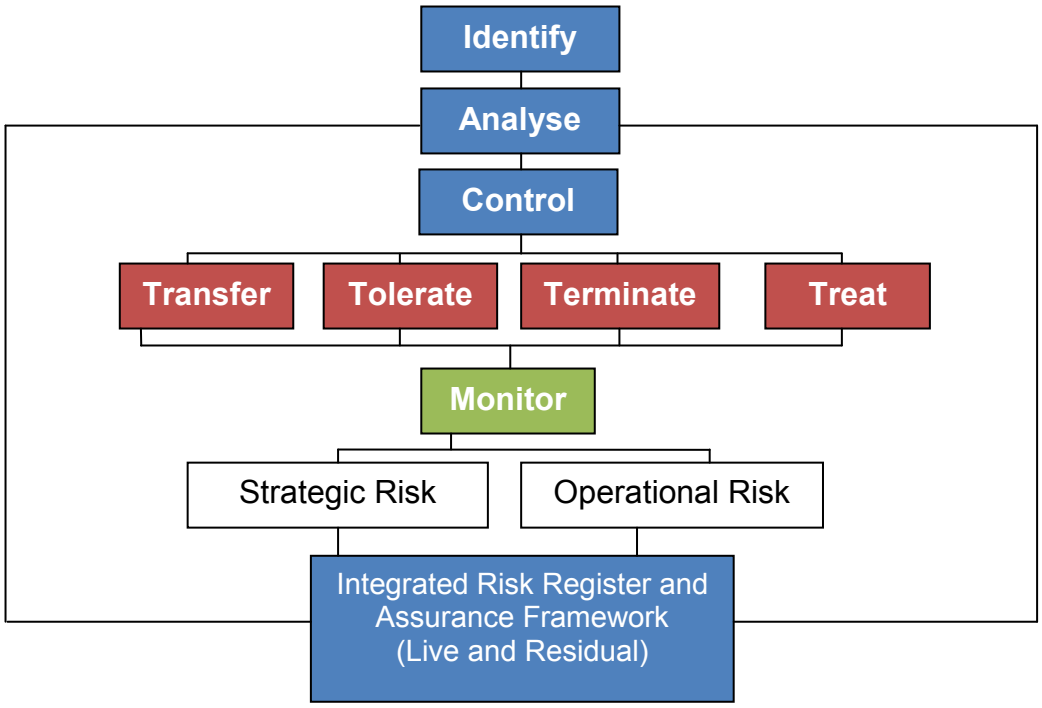
- Providing and safeguarding the highest standards of care for patients.
- Protecting staff, patients, the public, other stakeholders, the organisation's assets and reputation from the risks arising from its activities.
- Minimising risks associated with new development and service improvement activities
- Achieving this by maintaining a process by which there is a continuous and systematic identification and recording and management of risk.

North Cumbria University Hospitals NHS Trust has a duty to keep relevant stakeholders informed and where appropriate to involve them on the management of significant risks faced by the Trust. This is especially important where the risk is shared or may have an impact upon our stakeholders. The method of communication will depend upon the individual risk and the circumstances at the time.

In order to have consistency throughout the organisation, the Trust has introduced a specific framework for the assessment, identification and evaluation of risk. Section 9.1.4 below details the aspects of this framework and provides a simple visual aid for all staff.

9.1 Risk Assessment Framework

The figure below outlines the overarching framework for risk assessment across the organisation from identification to the entry onto the integrated risk register and assurance framework.



9.1.1 Risk Assessment and Identification

The Trust has a number of mechanisms where risk assessment and identification of risk takes place. These include:

- External scrutiny and inspections eg internal/external audit reports, CQC, NHSLA
- Occurrences such as incident reporting, claims, complaints
- Internal assessments eg SABS, EIA of policies
- Business Planning including production of business cases
- Project implementation
- Operational assessment of risk at ward and departmental level

9.1.2 Risk Analysis and Control

The Trust uses the 5 x 5 matrix as recommended by the National Patient Safety Agency and this is detailed in Appendix 4. This is a generic matrix, which is used to assess the full range of risks ie; clinical, non-clinical, operational, strategic and financial.

The 5 x 5 matrix identifies a risk score by reviewing the likelihood of the risk occurring and the consequence this will have as a result.

Staff guidance has been developed to support the use of the Risk Assessment, Identification and Evaluation Framework and can be found in the Trust's Risk Assessment Policy. Where a risk has been identified appropriate controls have been put in place to mitigate or control the risk to an acceptable level. All identified risks must have a treatment plan. There are four treatment plan options called the 4 "Ts".

Tolerate Accept the risk at its current level (with adequate controls in place)

Transfer Transfer the risk to another party where further controls or actions are required in order to adequately mitigate the risk. The consequences of this action will need risk assessing to ensure the risk is controlled as far as possible within the Trust's accountability.

Terminate Stop the activity that presents the risk. The consequences of this action will need risk assessing in terms of the impact on the provision of the Trust's services and local population.

Treat Take action to reduce or mitigate the risk, in terms of reducing the likelihood or its occurrence or reducing the severity of impact if it does occur.

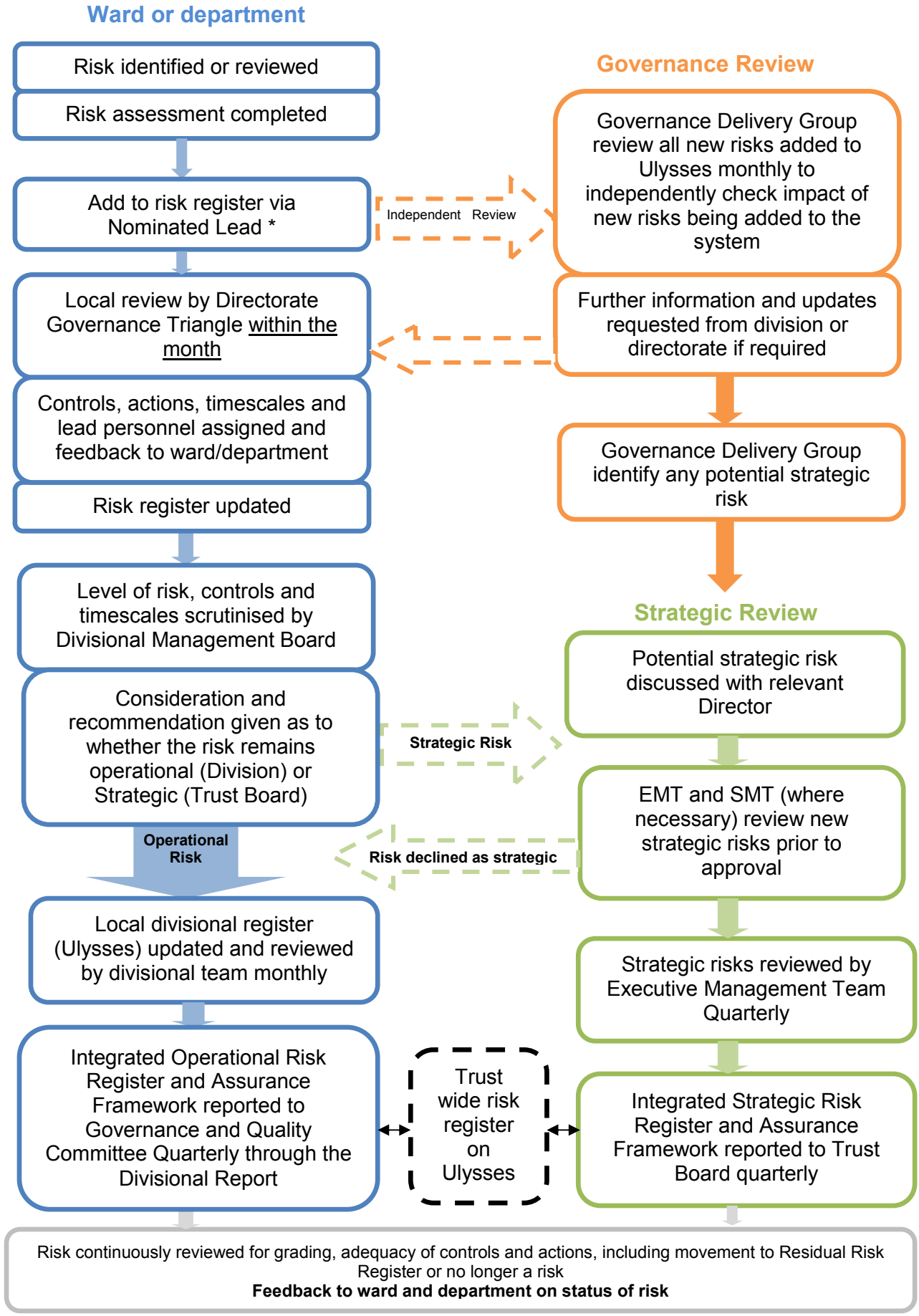
9.1.3 Risk Monitoring

The Trust has in place a specific process for the monitoring of risks across the organisation that categorises risks as either operational or strategic. Operational risks are those that can be managed and controlled within the clinical division. Strategic risks are risks which directly impact on the delivery of the organisations principal objectives. The combined divisional risk registers and strategic risk register provides the Trust wide integrated risk register and assurance framework which consists of operational and strategic risks. To ensure risks are managed through one system (Ulysses) any risk in the organisation must have an assurance section also completed that outlines:

- Controls against the risk
- Assurances/evidence that the controls are working
- Risk grading
- Assurance sources (types)
- Gaps in control
- Gaps in assurance

Diagram 9.1.4 illustrates how the risk assessment and escalation process operates across the Trust, including how this is monitored and reviewed.

9.1.4 Risk Assessment and Escalation Process



9.1.5 Managers Authority and reporting arrangements for Managing Risks

All members of staff have the responsibility to identify and complete a risk assessment within their area, including those which may arise from an incident, complaint, claim or near miss. All departmental heads, service leads and operational managers are empowered to manage the risks within their service area. Each department must have an identified 'nominated lead' to ensure all risk information is updated onto the Trust's Risk Management system which is Ulysses. All staff should have access to the on-line system to ensure incidents are reported.

Each directorate has an identified lead nurse, clinical director and governance facilitator who will review the risks monthly. This review includes the adequacy of controls (4T's) the actions taken and the timescales assigned for completion. Any updates from this review will be added to the risk register by the nominated lead for the division. For corporate departments, including HR, Finance, Estates, IM&T a nominated individual will also be assigned to liaise with the lead director. For Maternity Services, the Maternity Risk Management Strategy describes how the process for risk escalation works within the maternity service.

All risks pertaining to a Division are scrutinised monthly by the Divisional management team and reported to their Divisional Board. The Divisional Management Board will consider the status of the risks. The Divisional Management Board is empowered to re-grade and challenge the action plans to mitigate the risk and ensure the adequacy of the controls in place, including whether they require escalation to the Strategic risk register due to their impact on the organisations principal objectives.

The Divisional General Manager and Associate Medical Director will inform the relevant Director where the Divisional Management Board considers a risk to be strategic.

Strategic risks are then reviewed by the Executive Management Team (EMT) or the Senior Management Team (SMT) where appropriate, as part of updating the Integrated Risk register Assurance Framework prior to review and scrutiny by the Trust Board each quarter.

Operational risks, once approved by the Divisional Board, are updated and managed within the Divisional Team or 'Governance Triangle'. The Divisional General manager will report the status of their risk register as part of their quarterly report to the Governance and Quality Committee.

The Governance Quality Committee will highlight any specific issues in relation to risk management as part of their reporting and assurance to the Trust Board.

To ensure a 'fail safe' system is in place for all risks the governance Delivery Group will also review any risks which they consider may have a strategic impact which will be escalated to the relevant director by the Director of Nursing, Quality and governance or Medical Director.

New strategic risks will be reviewed and agreed by EMT and SMT where appropriate for inclusion onto the Integrated Strategic Risk Register and Assurance Framework. The Lead Director will communicate the EMT decision to the Division, where this relates to a specific clinical directorate or division.

The Trust Board will review and scrutinise the controls and mitigation plans in place for each of the strategic risks on a quarterly basis.

The Audit Committee will review the Integrated Risk register and Assurance Framework to ensure that it is fit for purpose and provides a basis to inform internal audit planning in line with the requirements set out in the Audit Committee Handbook July 2011.

9.2 System for the management of the Integrated Risk Register and Assurance Framework

The Trust has an online Risk Register, which is fully integrated with the Assurance Framework. The risk register is the record of the process of risk identification, analysis, evaluation, prioritisation and treatment process and forms the basis of the Trust's risk management planning for both operational and strategic risks. The risk register is held electronically and is the repository for all identified risks within the Trust.

Each risk, which is added to the register, is defined in terms of whether it is operational or strategic in terms of its impact. Each strategic risk is linked to the Trust's Strategic Aims and Objectives, to ensure that risks, which impact on the delivery of the Trust's principal objectives, are clearly identified.

Once a risk has been confirmed as a strategic risk, thus directly affecting at a strategic level the delivery of a strategic objective it is reviewed and reported to the Trust Board through the integrated risk register and assurance framework on a quarterly basis.

9.3 Incident management

The reporting and management of incidents is an integral part of the Trust's risk management arrangements. All members of staff have the responsibility to complete an incident form for an incident or near miss. Incident forms are completed via the on line reporting system.

The Trust has three main 'levels' for reviewing incidents:

9.3.1 Level 1 – General

These are general incidents which are reported every day on most clinical areas for example medication errors. Level 1 incidents are reviewed within the clinical division to ensure that peaks in incidents or trends are reviewed with plans put in place to mitigate the risk where necessary. All incidents at level 1 are included in the clinical divisions quarterly governance report which is reviewed by the Governance and Quality Committee.

9.3.2 Level 2 – High Level

These are incidents which are deemed by the clinical team within the division and the governance facilitator to be high level. This could include a serious breach of Trust policies or procedures or where an incident requires formal investigation but does not meet the SUI criteria set out in the Incident Management Policy.

9.3.3 – Level 3 – Serious Untoward Incident (SUI)

These are incidents which meet the criteria set out in the Trust's Incident Management Policy to be declared as a Serious Untoward Incident.

SUIs also link to the formal notification of external bodies of incidents or breaches of national policies, including Acts of Law.

9.4 Statement of Internal Control (SIC)

This discloses the ongoing process for identifying, evaluating and managing the significant risks faced by the Trust. The Audit Committee acts on behalf of the Board to maintain continuous assurance of the systems of internal control throughout the year.

9.5 Achieving Risk Awareness

To ensure risk management is effective throughout the organisation ALL staff must be "risk aware" at an appropriate level to their role within the Trust.

All staff receive an introduction to governance and risk management as part of the Trust's Corporate Induction.

The Governance Facilitators provide mandatory training on risk assessment, patient safety and incident reporting throughout the year for all staff as detailed within the agreed Training Needs Analysis.

10. RESPONDING TO EXTERNAL AGENCY VISITS & INSPECTIONS

The Trust is subject to a number of announced and unannounced inspections and accreditation visits or reviews from external agencies. The planning and outcomes from such visits are a core part of the Trust's governance and assurance arrangements.

A specific policy for the Management of External Agency Visits, Inspections and Accreditations (Assessments) is in place and should be adhered to by all staff. All External Agency visits should be formally notified by the procedure set out in the policy.

11. IMPLEMENTATION AND TRAINING REQUIREMENTS

Effective risk management depends on all staff having a clear understanding of the subject and the contribution they can make to risk control.

As an integral part of the Trust's Organisational Development, there will be an Education and Training Strategy and associated Training Needs Analysis (TNA) linked to the Trust's training prospectus.

The TNA will include appropriate and targeted Risk Management training, which will detail at least the NHSLA's minimum data set requirements, ensuring that staff members have sufficient awareness and competence to identify hazards, assess and manage risk within their working environment.

Managers will be responsible for ensuring that their staff are able to access and attend training appropriate to their needs including statutory and mandatory training. Individual members of staff also have a responsibility, through their Personal Development Plans, to identify and participate in risk management training. New staff will receive information on risk management as part of the organisation's general induction arrangements.

The Trust will implement and promote this strategy in the following ways:

- All lead individuals identified in this strategy will receive a copy of the strategy to ensure they are fully aware of their duties and responsibilities.
- The strategy will be presented to each of the Divisional Management Boards.
- The Strategy will be issued to the core leads identified in the 'Governance Triangle'.
- It will be available on the Trust internet.
- All staff will be notified of the availability of the Strategy and will be requested to read it.

- The Trust will bring this strategy and the core pillars of governance to the notice of all new employees at Induction.
- The Trust will promote strategy and policy in risk training.

12. PROCESS FOR MONITORING COMPLIANCE WITH THIS STRATEGY

This Strategy will be reviewed and approved by the Trust Board annually. The key reports produced, which are integral to compliance with this strategy will provide the Board with assurance against the delivery of this strategy across the organisation. This will include the Trust Board ratifying the Governance, Risk and Quality priorities on an annual basis.

The Trust Board will review annually the supporting structure for risk management including the core committee structure for the organisation.

Trust Board will review the strategic risks within the Integrated Risk Register and Assurance Framework quarterly.

The annual Governance Report will include an update on the effectiveness of the local arrangements for the management of risk across the organisation.

13. GOVERNANCE, RISK & QUALITY PRIORITIES FOR 2011/12

The key priority for the Trust for 2011/12 is to deliver the Governance Improvement plan following the review of clinical governance which was concluded in July 2011.

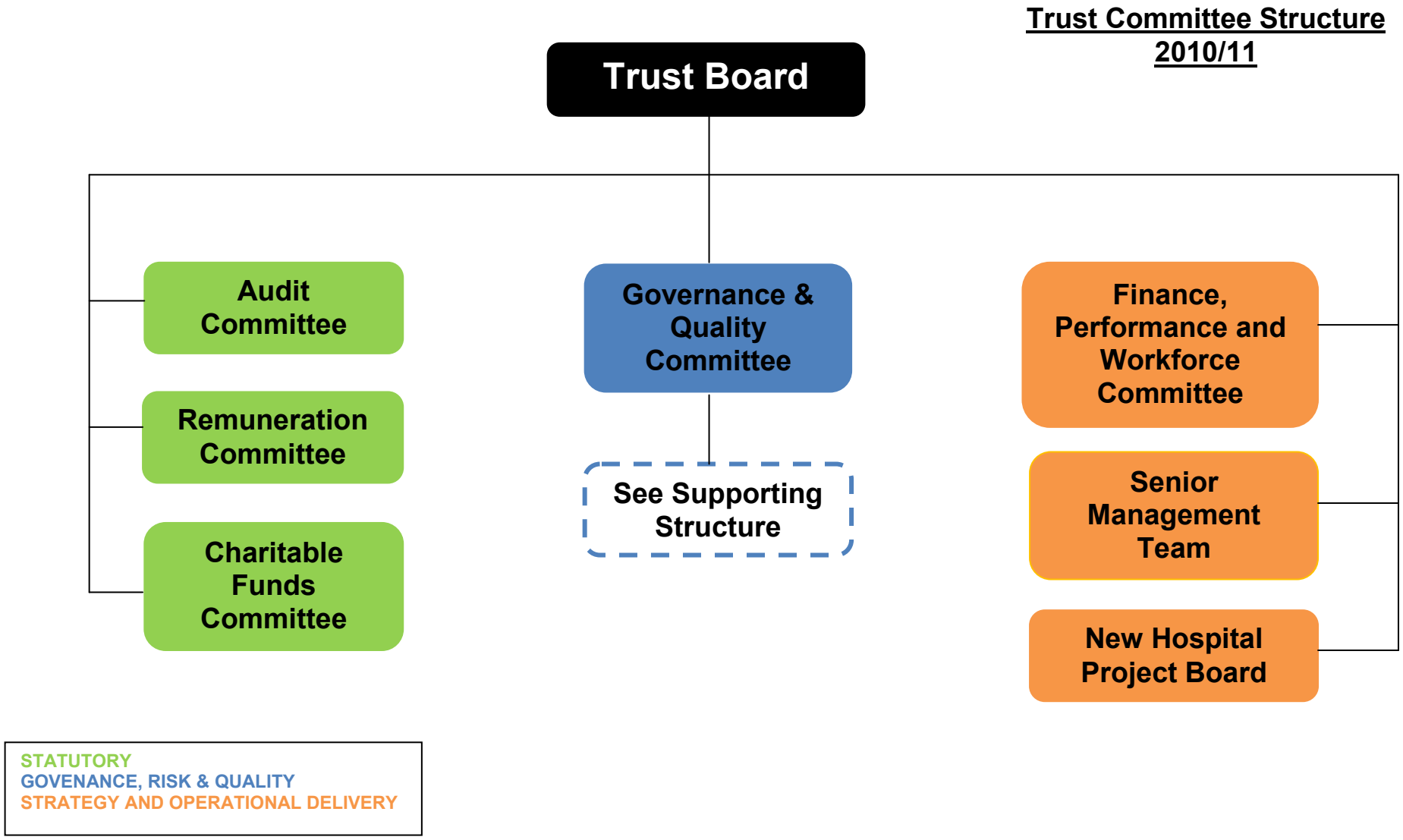
APPENDIX 1 – DEFINITIONS USED

- **Risk** is the probability of something happening that will impact on the organisation's ability to achieve its objectives (e.g. loss, injury or other adverse consequence)

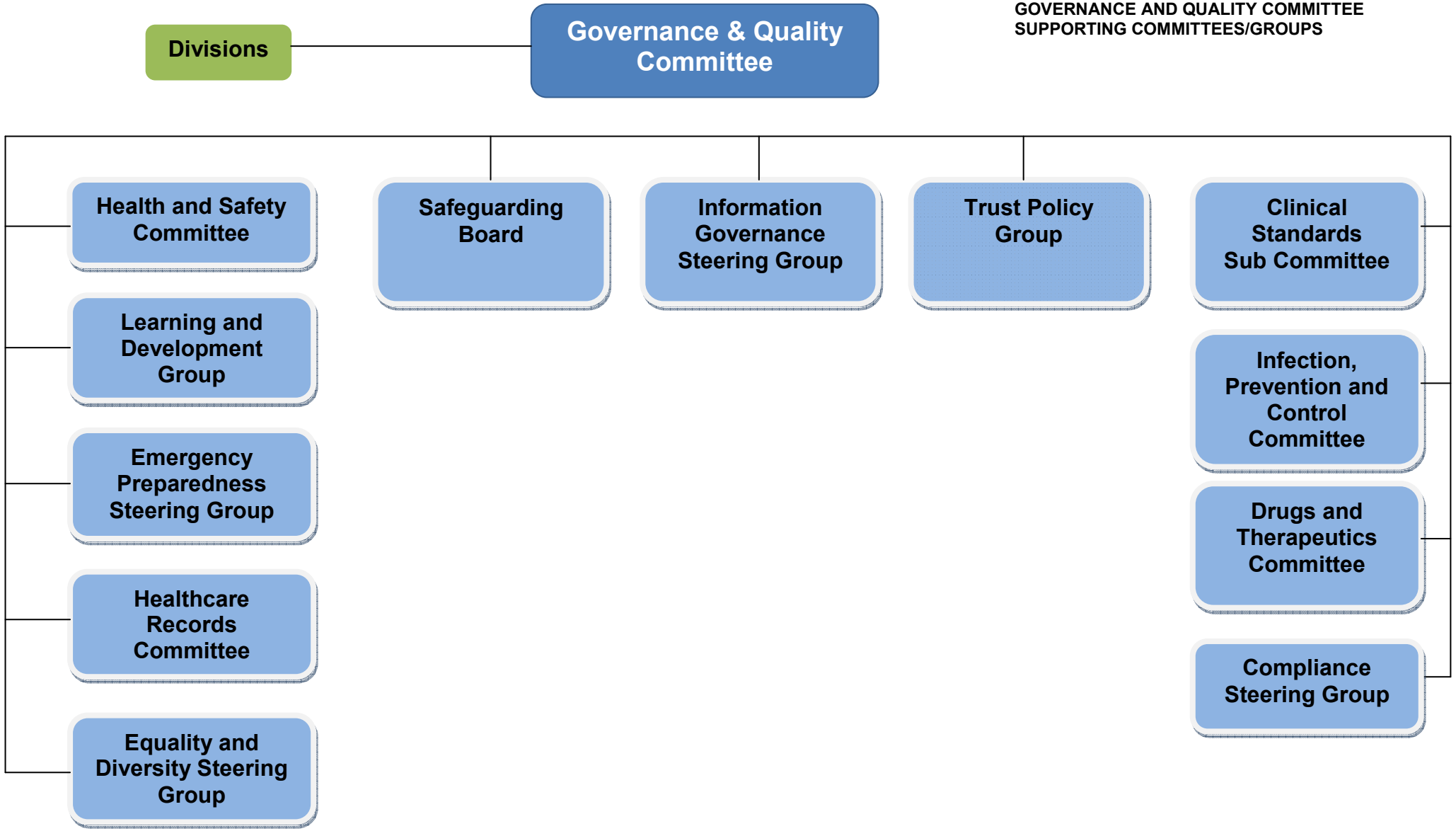
- **Untoward Incident (Sometimes called Adverse Events)**. Any incident/near miss event or circumstance arising during NHS service provision that could have or did lead to unexpected harm, loss or damage. Untoward Incidents can range from no harm untoward incidents to Serious Untoward Incidents.
- **Near Miss**. Where no harm, loss or damage is caused but could have resulted in harm, loss or damage in other circumstances.
- **Harm,** in the context of Patients, is defined as injury (physical or psychological), disease, suffering, disability or death. In most cases harm can be considered to be unexpected if it is not related to the natural cause of the patient's illness or underlying condition.
- **Acceptable Risk (Sometimes called Tolerable Risk).** A risk that is allowed to exist so that certain benefits can be gained, whilst there is an acceptable level of confidence that the risk is under control and that the risk has been reduced to the lowest practicable level.
- **Integrated Governance;** is defined as systems, processes and behaviours that highlights the interdependence of all aspects of governance
- **Corporate Governance;** is a system by which an organisation is directed and controlled at it's most senior levels in order to achieve its objectives and meet the necessary standards of accountability, probity and openness.
- this provides the Trust Board with a simple but comprehensible method for the effective and focussed management of the principle risks to meet its objectives. It also provides a structure for the evidence to support the Statement of Internal Control.
- **Statement of Internal Control (SIC);** is an annual statement by the Chief Executive, on behalf of the organisation, which highlights the internal control mechanisms within the organisation. The statement is supported by the Head of Internal Audit Opinion on the internal controls.
- **Clinical Governance;** this is the framework by which the Trust is accountable for continually improving the quality of our services and safeguarding high standards by creating an environment in which excellence will flourish.
- **CQC Registration;** this is the method by which the Trust is permitted to provide services to the population and collects evidence to ensure registration with the regulatory body is maintained.
- **CSSG;** Clinical Standards Sub Group

- **EMT;** Executive Management Team
- **SMT;** Senior Management Team
- **TPG;** Trust Policy Group
- **CQC;** Care Quality Commission
- **SIC;** Statement on Internal Control
- **NHSLA;** National Health Service Litigation Authority
- **CNST;** Clinical Negligence Scheme for Trusts
- **NHS;** National Health Service
- **EIA;** Equality Impact Assessment
- **SUIs;** Serious Untoward Incidents
- **STEIS;** Strategic Executive Information System
- **HSE;** Health and Safety Executive
- **ALE;** Auditors Local Evaluation
- **H&S;** Health & Safety

APPENDIX 2 – TRUST COMMITTEE STRUCTURE



GOVERNANCE AND QUALITY COMMITTEE SUPPORTING COMMITTEES/GROUPS



North Cumbria University Hospitals NHS
NHS Trust

APPENDIX 3

- To obtain the most up to date copy of the terms of reference for the Trust's committees please contact the relevant leads listed below.
- Alternatively copies up to date copies can be access via the Trust's website www.ncuh.nhs.uk

COMMITTEE	CONTACT
TERMS OF REFERENCE FOR GOVERNANCE & QUALITY COMMITTEE (and terms of reference for supporting committees/groups)	Gillian.hetherington@ncuh.nhs.uk
TERMS OF REFERENCE FOR AUDIT COMMITTEE	Jean.lynch@ncuh.nhs.uk
TERMS OF REFERENCE FOR CHARITABLE FUNDS COMMITTEE	Jean.lynch@ncuh.nhs.uk
TERMS OF REFERENCE FOR REMUNERATION COMMITTEE	Jacky.stockdale@ncuh.nhs.uk
TERMS OF REFERENCE FOR CLINICAL STANDARDS SUB COMMITTEE	Emma.Tryhorn@nuch.nhs.uk
TERMS OF REFERENCE FOR GOVERNANCE DELIVERY GROUP	Gillian.hetherington@ncuh.nhs.uk
TERMS OF REFERENCE FOR GOVERNANCE SCRUTINY GROUP	Gillian.hetherington@ncuh.nhs.uk
TERMS OF REFERENCE FOR EMERGENCY PREPAREDNESS STEERING GROUP	Helen.crellin@ncuh.nhs.uk
TERMS OF REFERENCE FOR COMPLIANCE STEERING GROUP	Kath.crook@ncuh.nhs.uk
TERMS OF REFERENCE FOR THE LEARNING & DEVELOPMENT GROUP	Bev.peascod@ncuh.nhs.uk
TERMS OF REFERENCE, SAFEGUARDING BOARD	Gillian.hetherington@ncuh.nhs.uk
TERMS OF REFERENCE, INFORMATION GOVERNANCE STEERING GROUP	Paul.wiggins@ncuh.nhs.uk
TERMS OF REFERENCE, TRUST POLICY GROUP	Helen.kelly@ncuh.nhs.uk
TERMS OF REFERENCE FOR HEALTHCARE RECORDS COMMITTEE	Paul.wiggins@ncuh.nhs.uk
TERMS OF REFERENCE FOR INFECTION, PREVENTION AND CONTROL	Elaine.haraldsen@ncuh.nhs.uk Suzette.johnston@ncuh.nhs.uk
TERMS OF REFERENCE FOR DRUGS AND THERAPUETICS COMMITTEE	Bill.glendinning@ncuh.nhs.uk
TERMS OF REFERENCE FOR THE HEALTH AND SAFETY COMMITTEE	Julie.cowan@ncuh.nhs.uk
TERMS OF REFERENCE FOR THE EQUALITY AND DIVERSITY STEERING GROUP	Kath.crook@ncuh.nhs.uk

Appendix 4 Model Matrix

Choose the most appropriate domain for the identified risk from the left hand side of the table. The work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

NHS National Patient Safety Agency

For the full *Risk matrix* for risk managers, go to www.npsa.nhs.uk

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	• Minimal injury requiring no/minimal intervention or treatment • No time off work	• Minor injury or illness, requiring minor intervention • Requiring time off work for >3 days. • Increase in length of hospital stay by 1-3 days.	• 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	• 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	• Incident leading to death • Multiple permanent injuries or irreversible health effects • An event which impacts on a large number of patients
Quality/Complaints/ Audit	• Peripheral element of treatment or service suboptimal • Informal complaint/inquiry	• 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	• 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	• Non-compliance with national standards with significant risk to patients if unresolved • Multiple complaints/ independent review • Low performance rating • Critical report	• 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
Human Resources/Organisational Development/Staffing/Competence	• Short-term low staffing level that temporarily reduces service quality (<1 day)	• Low staffing level that reduces the service quality	• 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	• 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 • No staff attending mandatory/key training	• 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.
Statutory Duty/Inspections	• No or minimal impact or breach of guidance/statutory duty	• Breach of statutory legislation • Reduced performance rating if unresolved	• Single breach in statutory duty • Challenging external recommendations/improvement notice	• Enforcement action • Multiple breaches in statutory duty • Improvement notices • Low performance notices • Critical report	• Multiple breaches in statutory duty • Prosecution • Complete systems change required • Zero performance rating • Severely critical report

Adverse Publicity/Reputation	• Rumours • Potential for public concern	• Local media coverage - short-term reduction in public confidence • Elements of public expectation not being met	• Local media coverage - long-term reduction in public confidence	• National media coverage with <3 days service well below reasonable public expectation	• National media coverage with >3 days service well below reasonable public expectation MP concerned (questions in the House) • Total loss of public confidence
Business Objectives/Projects	• Insignificant cost increase/ schedule slippage	• <5 percent over project budget • Schedule slippage	• 5-10 percent over project budget • Schedule slippage	• Non-compliance with national 10-25 percent over project budget • Schedule slippage • Key objectives not met	• Incident leading >25 percent over project budget • Schedule slippage • Key objectives not met
Finance including Claims	• Small loss Risk of claim remote	• Loss of 0.1-0.25 percent of budget • Claim less than £10,000	• Loss of 0.25-0.5 percent of budget • Claim(s) between £10,000 and £100,000	• Uncertain delivery of key objective/Loss of 0.5-1.0 percent of budget • Claim(s) between £100,000 and £1million • Purchasers failing to pay on time	• Non-delivery of key objective/Loss of >1 percent of budget • Failure to meet specification/ slippage • Loss of contract/payment by results • Claim(s) >£1million
Service/Business Interruption Environmental Impact	• Loss/interruption of >1 hour • Minimal or no impact on the environment	• Loss/interruption of >8 hours • Minor impact on environment	• Loss/interruption of >1 day • Moderate impact on environment	• Loss/interruption of >1 week • Major impact on environment	• Permanent loss of service or facility • Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur,possibly frequently

Note: the above table can be tailored to meet the needs of the individual organisation.

Some organisations may want to use probability for scoring likelihood, especially for specific areas of risk which are time limited. For a detailed discussion about frequency and probability see the guidance notes.

Table 3 Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Note: the above table can to be adapted to meet the needs of the individual trust.

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Instructions for use

1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2 Use table 1 (page 13) to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

3 Use table 2 (above) to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

4 Calculate the risk score the risk multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

5 Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.