APPENDIX 1

North Cumbria University Hospitals NHS
NHS Trust

Governance & Risk Management Strategy 2013 – 2014

INTERIM UPDATE - JULY 2013

DOCUMENT CONTROL

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Trust Board Initial Strategy	Date: 06/07/2010
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This document supersedes or replaces the following documents:

- Governance, Risk and Quality Strategy 2011/13
- Risk Management Strategy 2009/11
- Quality Improvement Strategy 2009/10
- Governance Strategy 2008/9

Please note that the Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as "uncontrolled" and as such, may not necessarily contain the latest updates and amendments.

Approved policies related to this policy

Name Policy
Maternity Risk Management Strategy
Risk Assessment Policy
Management of External Visits Policy
Incident Management Policy & Guide to Investigating Incidents

Statement of changes made to date:

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
1.2	18/01/2012	Final proof prior to publication following ratification by Trust Board January 2012.
3.0	01/07/2013	Interim update required to strategy in accordance with impending acquisition. Specifically in relation to key Board committees and the section relating to quality.

SUMMARY

This document provides the overarching framework for governance and risk management 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.

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

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 and Risk Management 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

3.1 Governance

Governance can be defined as - '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 can be defined as '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.

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

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, Safety and Quality Committee, Assurance Committee and Business Unit Clinical Governance 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.

Responsibility for the day-to-day management of risk is devolved locally to the Business Units 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 incidents are reported and investigated in order to ensure that lessons are learnt and shared.
- Escalate risks that cannot be managed locally to the relevant senior manager.
- Ensure all staff comply with this Strategy and associated procedures.
- Ensure that governance and risk management is an integral part of appraisal and staff development.
- Monitor action plans associated with improvements to clinical governance in their area.

6.4 Business Unit (Local Risk Management) Responsibilities

Each Business Unit has a number of wards and departments that will provide assurance to the Business Unit Governance Boards that:

- Untoward incidents and near misses are reported by all wards, departments and staff groups.

- Untoward incidents and near misses are investigated appropriately.
- Serious complaints are investigated.
- 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.
- Compliance with key regulatory bodies in relation to their specialty.
- Ensure this strategy and the core pillars of governance are embraced and developed within their Business Unit.

Through the Business Unit Directors and Deputy Business Unit Directors the Business Units are required to assure the Safety & Quality Committee and Assurance 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 Business Unit.
- The Business Unit Governance 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 Business Unit Management Team.
- The Business Unit Risk Register is updated and reviewed monthly by the Business Unit.
- Incidents and near misses are reported and immediately investigated or escalated.
- All serious incidents (SIs) are appropriately escalated.
- SI investigations are conducted according to Trust Policy.
- Any actions arising from SI 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 Business Unit 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 Business Unit Boards and all those staff with managerial and supervisory responsibility, will have risk management responsibilities defined in their job descriptions.

Each Business Unit has a named Governance Lead who has the responsibility to facilitate the co-ordination of risk management and risk education within the division.

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 Governance Facilitator

- Support the Business Unit management team to ensure that sound systems of clinical governance are in place.
- Provide leadership and support for the development, implementation and monitoring of risk management within the division (in conjunction with the Deputy Business Unit Director).
- With the Professional Head/Lead, co-ordinate, develop and drive the governance process for the management of incidents.
- Develop and maintain the risk register (via Ulysses) and report to the Business Unit management board.
- Provide a written report to each Business Unit clinical governance meeting.
- Facilitate the co-ordination of risk management and risk education within the Business Unit.

6.6 Medical Director (MD)

- Responsibility for ensuring effective systems and processes are in place to support the delivery of safe quality care (jointly with 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).
- Ensure that Serious Incidents are managed, investigated and lessons learned where necessary.
- Advise the Trust Board on any issues relating to clinical governance.

6.7 Director of Nursing & Quality (DoN)

- Executive Director with responsibility for safeguarding
- 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).
- Ensure that Serious Incidents are managed, investigated and lessons learned where necessary.
- 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 Governance & Company Secretary

- Ensure that the Board has in place effective systems and processes for governance and risk management, this includes associated reports (jointly with MD and DoN).
- 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 Trust 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.
- 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 Governance Statement.

6.8 Director of Operations

- Ensure that the Business Units 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 Business Unit Reviews contribute to effective governance and performance monitoring.
- Ensure that this Strategy is embedded within the Business Units.

6.9 Director of Finance

- 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.
- Delivery and monitoring of workforce related CQC essential standards.

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.
- Delivery and monitoring of estates and facilities related CQC essential standards.

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 Business Units 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 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.
- Ensure robust processes exist to learn from patient complaints.
- Ensure a robust litigation service is in place.

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.

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 a agreed terms of reference (copies of the terms of reference can be accessed via appendix 3).

7.2.1 Safety and Quality Committee

This is a Committee of the Trust Board with the responsibility for gaining assurance in relation to the provision of safe quality care. This includes delivering care to best practice standards and evidencing that the care we give is effective.

This committee is a key part of building our safety culture by ensuring that the clinical Business Units have robust systems in place for clinical governance.

There are a number of sub committees and reporting groups which will report to this committee and will escalate any issues of concern:

- Management of deteriorating patient group
- Infection prevention committee
- Nutrition steering group
- Safeguarding Board
- Healthcare Records Committee
- Drugs and Therapeutics Committee
- Information Governance Steering Group
- Medical Devices Committee

This committee is chaired by a Non-Executive Director and meets 10 times per year, with quarterly meetings being dedicated to receiving an assurance report from each of the Clinical Business Units on their Clinical Governance arrangements.

7.2.2 Assurance Committee

This is a Committee of the Trust Board with the responsibility for gaining assurance that the process for managing risk is effective and compliance with key regulators is well managed across the Business Units, this includes the CQC.

This committee will ensure that appropriate control and escalation systems are in place for the management of risk across the clinical Business Units and corporate functions. This committee will ensure a 'live' connection with the Board Assurance Framework which will be updated after each meeting and reported to the Trust Board.

There are a number of sub committees and reporting groups which will report to this committee and will escalate any issues of concern:

- Health and Safety Committee
- Emergency Preparedness Steering Group
- Estates and Facilities Group
- Trust Policy Group

This committee is chaired by a Non-Executive Director and meets quarterly.

7.2.3 Workforce Committee

This is a Committee of the Trust Board with the responsibility for gaining assurance that the Trust has in place sounds systems to support and develop its workforce in order to achieve the organisations objectives and provide safe care for patients.

There are a number of sub committees and reporting groups which will report to this committee and will escalate any issues of concern:

- The Learning Development Group
- Equality and Diversity Steering Group

This Committee will also ensure that any issues from partnership working with the Trade Unions are escalated and managed, specifically:

- Trust Partnership Forum
- Joint Local Negotiating Committee

This committee is chaired by a Non-Executive Director and meets 10 times per year.

7.2.4 Finance, Investment and Performance Committee

This is a Committee of the Trust Board with the responsibility for reviewing performance against mandatory and contractual targets as well as reviewing investment decisions which require scrutiny due to financial value or strategic impact.

This committee is chaired by a Non-Executive Director and meets 10 times per year.

7.2.5 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 committee also reviews the assurance gained from the Trust's Clinical Audit function.

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)

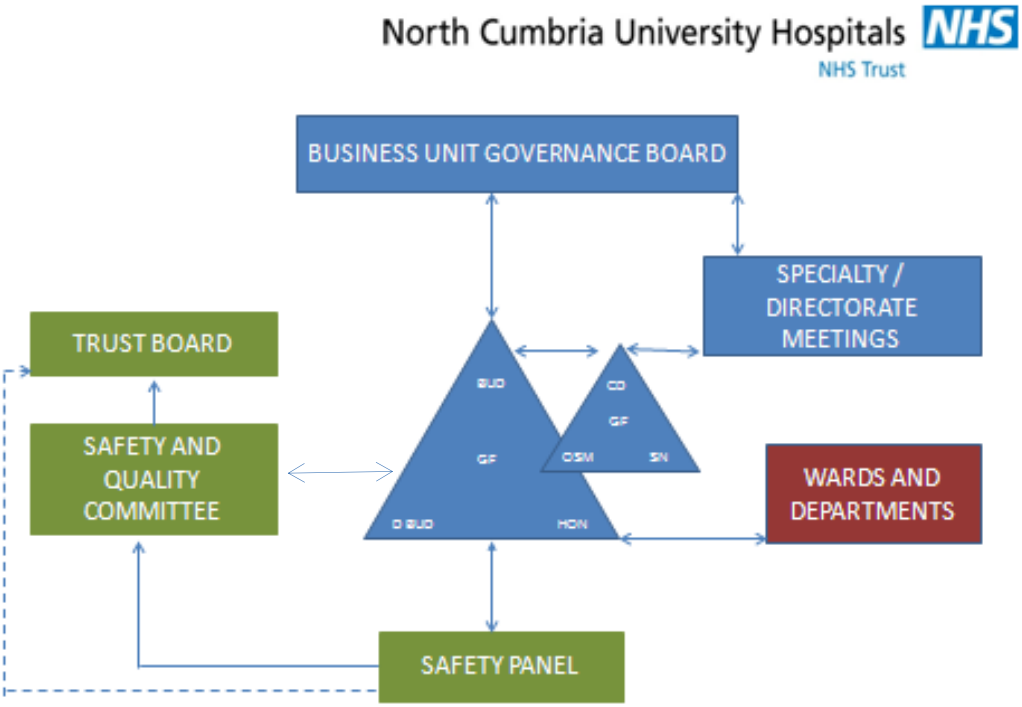
The Trust Board also has operational delivery and strategic delivery committees as part of its overall committee structure which are listed in Appendix 2. This includes:

- Executive Management Team
- New Hospital Project Board
- Finance, Investment and Performance Committee
- Clinical Policy Group

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 Business Units to support the delivery of robust clinical governance.



BUD = Business Unit Director, HoN = Head of Nursing/Head of Midwifery, DBUD = Deputy Business Unit Director GF = Governance Facilitator, CD= Clinical Director, OSM = Operational Services Manager, SN/M = Senior Nurse/Midwife

7.3.1 Clinical Business Units

Within each Clinical Business Unit there is a Business Unit Director, Deputy Business Unit Director, Head of Nursing and Governance Facilitator who have the collective responsibility for ensuring robust clinical governance arrangements exist in practice. Each Business Unit is made up of specialties/directorates that have a Clinical Director, Operational Service Manager and Senior Nurse.

The Clinical Business Units have a Clinical Governance Board which has multidisciplinary representation from the individual directorates/specialties.

7.3.2 Safety Panel

The Safety Panel consists of the Medical Director, Associate Medical Director, Director of Nursing, and Deputy Director of Nursing, Director of Governance and Head of Governance. The safety panel meets weekly and has a set programme of work:

- Week one – Serious Incidents
- Week two – Mortality
- Week three - Serious Incidents
- Week four – Complaints and litigation
- Week five – Patient experience

The safety panel reviews category A and B serious incidents and approves the final reports, recommendations and ensure an audit date is allocated to review implementation of recommendations.

The safety panel also ensures that any alerts relating to mortality are acted on and reviewed within the clinical teams.

Serious complaints are also reviewed by the safety panel.

The key outputs in relation to serious incidents, complaints, mortality, litigation and patient experience are reported to the Safety and Quality Committee and Trust Board.

7.3.4 Governance Assurance and Monitoring

To ensure ward to board monitoring is in place across the Clinical Business Units, specific arrangements with key board sub committees:

Board Sub Committee	**Business Unit Reporting – Core Items**
Safety and Quality	Quarterly reports on safety, quality and experience, including progress with implementing robust clinical governance arrangements.
Assurance Committee	Quarterly reports on risk register updates and compliance with key regulators, including CQC declarations.
Workforce Committee	Quarterly reports on mandatory training and appraisals.

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

External audit 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. BEING OPEN AND DUTY OF CANDOUR

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".

Being open with patients and their families or carers when they are involved in a patient safety incident which has resulted in moderate, severe or catastrophic harm is a contractual obligation for all NHS providers under the Duty of Candour.

The sharing of learning is a fundamental part of our clinical governance framework in order to ensure that we build resilience and a journey of continuous improvement for both patients and our staff.

9. THE RISK MANAGEMENT PROCESS

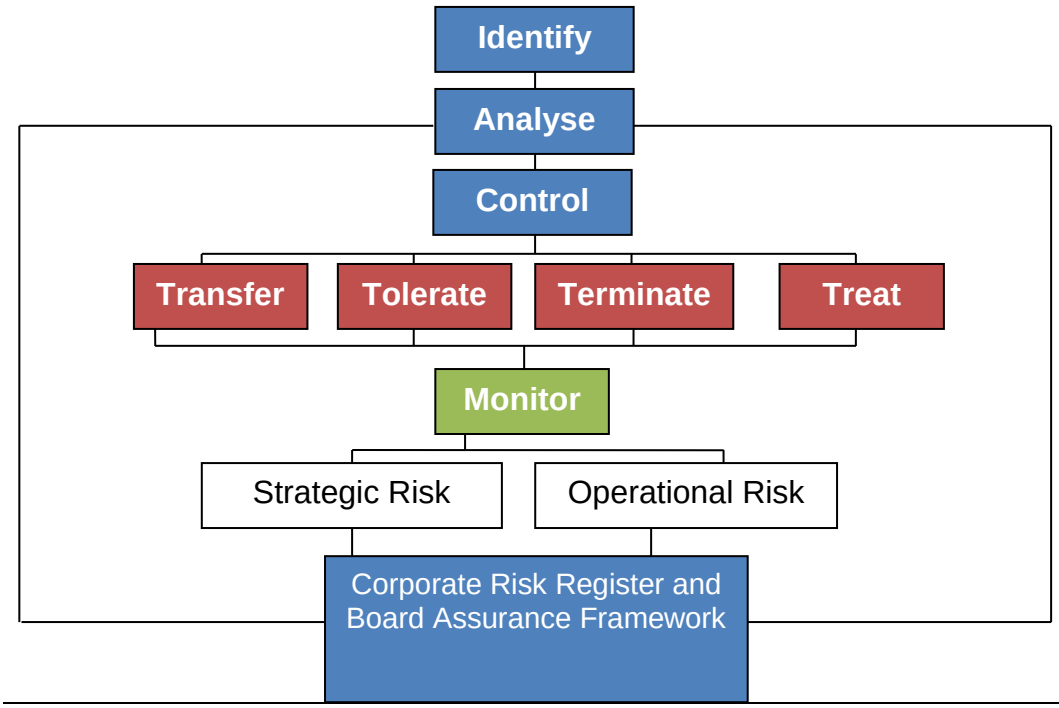
This is the term applied within the NHS for the application of a systematic method of identifying, analysing, evaluating controlling, monitoring and communicating the risks associated with any activity, process or function necessary for the achievement of the organisation's objectives. The Trust is committed 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. The Trust's risk assessment policy outlines the process for the assessment, identification and evaluation of risk.

a. 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 with the controls the in place to mitigate as far as possible the risk. All risks in this category will have a residual rating recorded on the register.

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 Business Unit. Strategic risks are risks which directly impact on the delivery of the organisations principal objectives. The combined Business Unit risks, corporate function risks and strategic risks provide the Trust wide corporate risk register. Risks which have a direct impact on the delivery of a principal objective are escalated onto the Board Assurance Framework.

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

9.1.4 Risk Assessment and Escalation Process

Each quarter the Assurance Committee reviews the risk registers of the corporate departments and clinical Business Units to review any risks which require escalation onto the Board Assurance Framework**.** The Trust Board receives a report each quarter on the Board Assurance Framework and the movement of strategic risks.

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.

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 any operational risks they may have. For

Maternity Services, the Maternity Risk Management Strategy describes how the process for risk management works within the maternity service.

All risks pertaining to a Business Unit are scrutinised monthly by the Business Unit management team and reported to their Boards at each meeting. The Board will consider the status of the risks and 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 Board Assurance Framework due to their impact on the organisations principal objectives.

The Business Unit Director and Deputy Business Unit Director will inform the relevant Director where the Business Unit Management Team considers a risk to be strategic.

Strategic risks are then reviewed by the Assurance Committee and relevant Director as part of updating the Board Assurance Framework.

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

To ensure a 'fail safe' system is in place for all risks the Governance Facilitator will review all new risks with the divisional team to ensure appropriate escalation is in place where necessary.

New strategic risks will be reviewed and agreed by the directors for inclusion onto the Integrated Strategic Risk Register and Assurance Framework.

The Trust Board will review and scrutinise the controls and mitigation plans in place for each of the strategic risks on a quarterly basis as part of the review of the Board Assurance Framework. This will include any specific recommendations or areas requiring attention from the Assurance Committee.

The Audit Committee will review the Board 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.

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.

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.

Incidents are reported using the NPSA categories of harm which are 'mapped' against the Ulysses definitions of severity.

NPSA LEVEL OF HARM		ULYSSES SEVERITY
	Intervention was made therefore the actual impact was a near miss (1)	**Near Miss**
	**No Harm =** Impact was prevented resulting in no harm.	**Negligible/ Insignificant**
	**Low Harm =** Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care	**Minor**
	**Moderate Harm =** Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.	**Moderate**
	**Severe Harm =** Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.	**Major**
	**Death:** Any patient safety incident that directly resulted in the death of one or more persons receiving NHS-funded care	**Catastrophic**

Once the manager receives an incident they have the responsibility of confirming the severity of the initial incident reported, the likelihood of this occurring again and the actual impact of harm caused.

The investigation of incidents reported will depend on their final grading:

Low	Investigation will be carried out by the manager or person in charge for that particular clinical or non-clinical area.
Moderate	Investigation will be carried out by the manager or person in charge for that particular clinical or non-clinical area.
Major	Investigation will be carried out by the operational service manager/clinical director or senior nurse. Some Major incidents may also be Serious Incidents.
Catastrophic	Investigation will be carried out by identified case manager as the majority of these incidents will be Serious Incidents.

9.3.1 Serious Incidents

The national definitions for SIs are any incident that resulted in the following:

- **Unexpected** or **avoidable death** of one or more patients, staff, visitors or members of the public.
- **Serious harm** to one or more patients, staff, visitors or members of the public where the outcome requires **lifesaving intervention**, major or surgical/medical intervention, **permanent harm** or will **shorten life expectancy** or result in prolonged pain or **psychological harm**.
- A scenario that **prevents** the organisations **ability** to continue to **deliver services** for example loss of personal/organisational information, damage to property, reputation, environment or IT failure.
- Allegations of **abuse.**
- **Adverse media** coverage or public concern about the organisation or the wider NHS
- A **Never Event**

The trust has three specific categories for an SI:

GRADE	DEFINITION	National Grade
A	These will be incidents that are catastrophic, resulted in death and or permanent harm. These may also include serious service or system failures.	2
B	These will be incidents that have caused serious harm, have required significant intervention or have resulted in service or system failure.	1 or 2
C	These will be incidents where harm was caused, however they are not uncommon, for example falls resulting in a fracture. Category C SIs may also include occasions where there is significant learning to be gained across the organisation.	1

The trust guide to investigating incidents (July 2013) should be read for staff investigating incidents.

9.4 Annual Governance Statement (AGS)

The Annual Governance Statement outlines the system of control which has been in place throughout a given financial year in order to mitigate risks against the delivery of the organisations objectives.

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 issued to the core leads identified in the 'Governance Triangle' in the respective Business Unit Teams.
- 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.

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.

13. GOVERNANCE PRIORITIES FOR 2013/14

The Clinical Governance priorities for the Trust for 2013/14 are:

- Delivery of the Safety and Quality priorities 2013/14.
- Delivery the action plan arising from the Keogh Rapid Response Review
- Delivery of the CQC action plan following the inspections at WCH and CIC in 2013.
- Delivery of improvement plans in order to evidence compliance with outstanding CQC outcomes.
- Delivery of the Deanery action plan.
- Ensuring the requirements of the acquisition for governance are delivered within the required timeframes.

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)

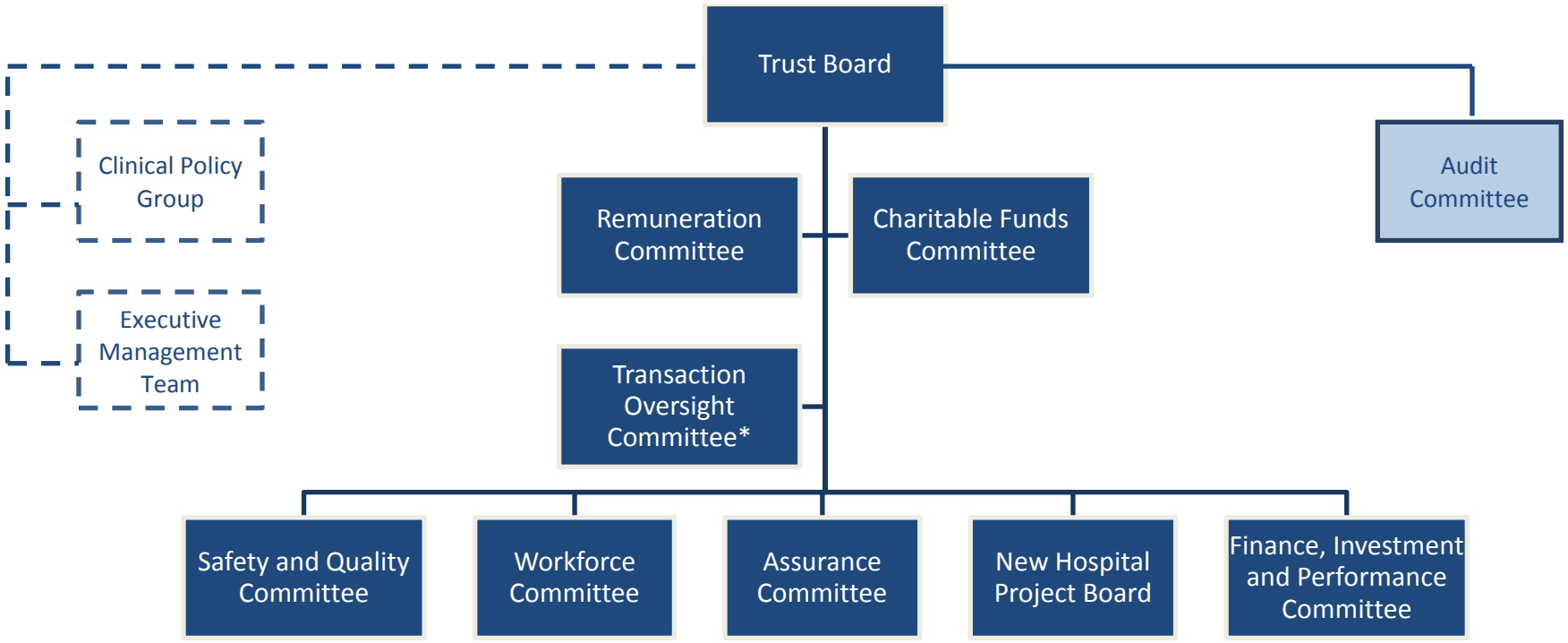
- **Untoward Incident (Sometimes called Adverse Events)**. Any incident/near miss event or circumstance arising during NHS service provision that could have or did lead to unexpected harm, loss or damage. Untoward Incidents can range from no harm untoward incidents to Serious Untoward Incidents.
- **Near 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 its most senior levels in order to achieve its objectives and meet the necessary standards of accountability, probity and openness.
- **Annual Governance Statement;** 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.

- **EMT;** Executive Management Team
- **TPG;** Trust Policy Group
- **CQC;** Care Quality Commission
- **AGS;** Annual Governance Statement

- **NHSLA;** National Health Service Litigation Authority
- **CNST;** Clinical Negligence Scheme for Trusts
- **NHS;** National Health Service
- **EIA;** Equality Impact Assessment
- **SIs;** Serious Incidents
- **STEIS;** Strategic Executive Information System
- **HSE;** Health and Safety Executive
- **ALE;** Auditors Local Evaluation
- **H&S;** Health & Safety

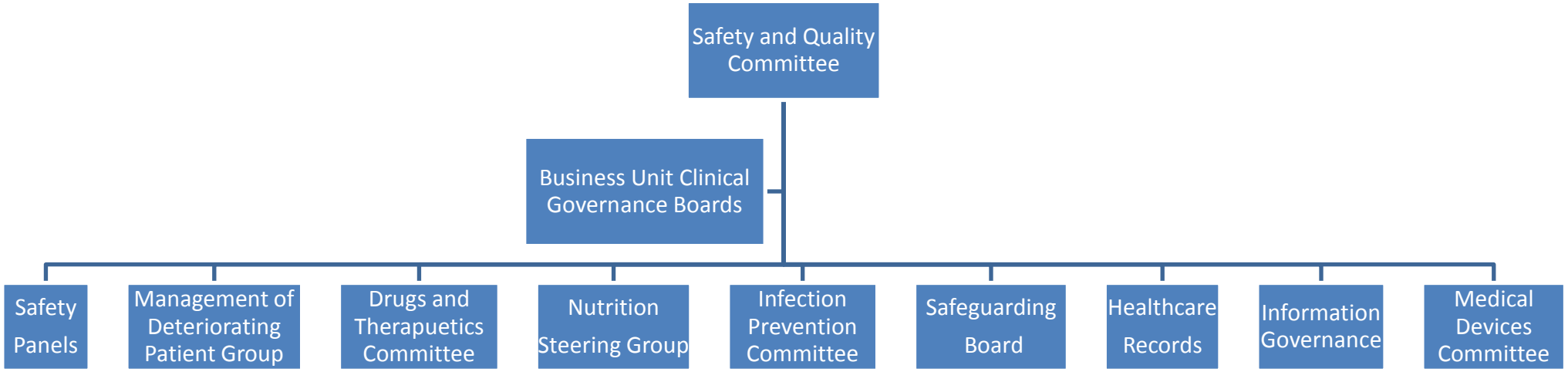
APPENDIX 2 – TRUST COMMITTEE STRUCTURE

Trust Committee Structure 2013/14

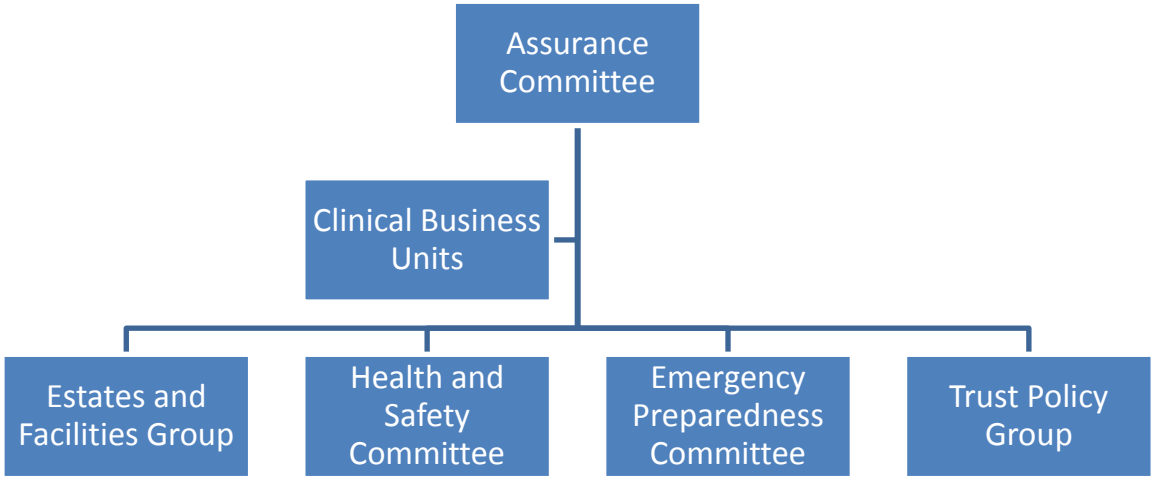


***Related to Acquisition**

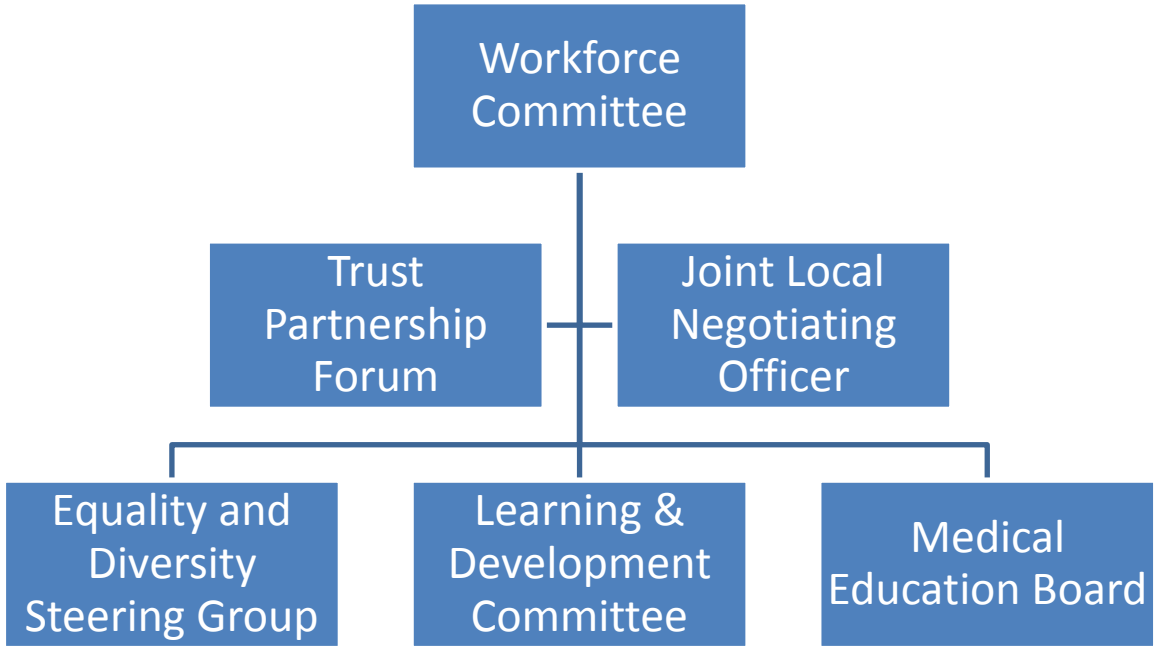
Committees / Groups reporting to Safety and Quality Committee



Committees / Groups reporting to Assurance Committee



Committees / Groups reporting to Workforce Committee



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 SAFETY & 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 WORKFORCE COMMITTEE (and terms of reference for supporting committees/groups)	Kath.crook@ncuh.nhs.uk
TERMS OF REFERENCE FOR FINANCE, INVESTMENT AND PERFORMANCE COMMITTEE	Jean.lynch@ncuh.nhs.uk
TERMS OF REFERENCE FOR REMUNERATION COMMITTEE	Jacky.stockdale@ncuh.nhs.uk
TERMS OF REFERENCE FOR ASSURANCE COMMITTEE (and terms of reference for supporting committees/groups)	Gillian.hetherington@ncuh.nhs.uk

APPENDIX 4 – RISK 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.

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	• 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

		not being met			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.