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

TRUST BOARD
15th December 2010

TITLE	Integrated Governance and Risk Management Strategy
EXECUTIVE SUMMARY	The Integrated Governance and Risk Management Strategy has undergone an annual review. Changes are detailed in the review communication form. The strategy sets out the governance framework for the Trust, responsibilities of staff and the process for risk management.
BOARD ASSURANCE (Risk) / IMPLICATIONS	The strategy is a key document for the Board and provides assurance that governance and risk process are in place, that Committee and staff responsibilities are made clear, and a mechanism for monitoring risk from 'Ward to Board' is evident.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Views have been sought from Executive team and senior managers through IGAC, General Managers' views have been sought. Feedback has been considered and incorporated into the policy
EQUALITY AND DIVERSITY ISSUES	Impact assessment has not identified any key issues
LEGAL ISSUES	None identified
The Trust Board is asked to:	Ratify the strategy
Submitted by:	Sarah Johnston on behalf of Susan Osborne, Interim Chief Nurse and Philip Beesley, Chair of IGAC
Date:	8th December 2010
Decision:	For approval

PROFORMA FOR RATIFICATION OF POLICIES PROCEDURES and GUIDELINES BY RATIFYING COMMITTEE

- Please complete this form electronically
- Include contact telephone numbers
- The boxes will expand as required

Policy/Guidelines Name:	Integrated Governance and Risk management Strategy
Name of Person completing form:	Sarah Johnston, Head of Quality and Integrated Governance
Date:	6th December 2010

Author(s) *(Principle contact)*	Sarah Johnston, Head of Quality and Integrated Governance
Name of author or sponsor to attend ratifying committee when policy/guideline is discussed	Philip Beesley, Chair of IGAC
Date of final draft	7th December 2010
Has this policy/guideline been thoroughly proof-read to check for errors in spelling, typing, grammar and consistency? *(delete as necessary)*	YES
By whom:	Sarah Johnston, Head of Quality and Integrated Governance
Is this a new or revised policy/guideline? *(delete as necessary)*	Revised – annual update
Describe the development process used to generate this policy/guideline. *Who was involved, which groups met, how often etc.?*	The strategy has been circulated to IGAC members for review and comments received re update. This includes the internal auditors
Who is the policy/guideline primarily for?	Senior managers but relevant for all staff
Is this policy/guideline relevant across the Trust or in limited areas?	Across the Trust
How will the information be disseminated and how will you ensure that relevant staff are aware of this policy/guideline?	Information will be disseminated via the intranet, and communications sent directly to key staff groups. Review of risk registers at IGAC, CGC and Safety and Risk Committee will require staff to be aware of the policy and this is demonstrated in processes followed, and review of risks
Describe the process by which adherence to this policy/guideline will be monitored. *(This needs to be explicit and documented for example audit, survey, questionnaire)*	Review of risk registers at IGAC, CGC and Safety and Risk Committee will require staff to be aware of the policy and this is demonstrated in processes followed, and review of risks.
Is there a NICE or other national guideline relevant to this topic? If so, which one and how does it relate to this policy/guideline?	No NICE guidance. National guidance relating to essential standards and the Quality and Risk profile is considered.
Has the policy been checked against minimum requirements for NHS LA Standards (if applicable)	YES
What (other) information sources have been used to produce this	Essential Standards for Quality and Safety (CQC publication March 2010) NHS Litigation Authority Risk

policy/guideline?	Management Standards for Acute Trusts (April 2008) Governing the NHS: A guide for NHS Boards (DH and NHS Appointments Commission, June 2003) Integrated Governance (hfma (Healthcare Financial Management Association) handbook, 2007) Integrated Governance Handbook (DH, February 2006) The Intelligent Board (Dr Foster, February 2006)
Has the policy/guideline been impact assessed with regard to disability, race, gender, age, religion, sexual orientation?	YES
Other than the authors, which other groups or individuals have been given a draft for comment?*(e.g. staff, unions, human resources, finance dept., external stakeholders and service users)*	Members of IGAC General managers
Which groups or individuals submitted written or verbal comments on earlier drafts?	Head of Corporate Affairs, Head of Customer Affairs, NHS LA lead
Who considered those comments and to what extent have they been incorporated into the final draft?	Head of Quality and Integrated Governance Comments considered and included - reference available on communication form
Have financial implications been considered?	YES – no implications
Proposed review date	Nov 2011

Policies Procedures and Guidelines Review Communication Form

Policy title:	Integrated Governance and Risk Management Strategy
Consultation start date:	14th November 2010
Deadline for feedback:	8th December 2010
Feedback to be provided to:	Sarah Johnston, Head of Quality

'Before and after' comparison of key changes:

Existing policy	New proposed policy
Reference to Audit Committee receiving BAF quarterly	Audit Committee to receive BAF at least annually, and on Chairman's request (this is facilitated by Chair being a member of IGAC and participating in full review of BAF at each IGAC meeting
References to ALE	Removal of reference to ALE following FT achievement as ALE will not be continued
Reference to 'building for FT'	Removal of building for FT – replaced with reference to embedding our risk management approach as we go forward as an FT
Paragraph on strategy for 2008-2011	Removal of key areas for improvement – improvements have been achieved. New improvements including further change to Clinical governance committee are referred to under specific headings other headings and the focus for embedding risk management is referenced in introduction
Drivers for Integrated Governance section in place to highlight move towards an integrated approach	Removed – integrated governance is well established in terminology and in practice
Set out against NHS LA standards 2009	Set out against NHS LA standards 2010
Out of date references	Terminology updated: for divisions/directors etc

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

INTEGRATED GOVERNANCE and RISK MANAGEMENT STRATEGY 2008- 2011

Date	Page(s)	Comments	Approved by
July 2008		Replaces Quality and Risk management Strategy 2004-2006	Trust Board
Nov 2009		Annual Review and updates Nov 2009 Addition of 1.2.i to indicate progress on key areas of change being implemented Amendments to 4; changes in responsibilities Addition of 5.2 reference to new Committee and Group Policy Addition of Appendix C Corporate Risk Register process and minor rewording to reflect this under corporate risk register heading page 17	IGAC on behalf of the Trust Board
July 2010		Administrative update; removal of references to HCC and core standards and replacement with CQC and essential standards information. Removal of roles now longer in post, addition of Head of Corporate Affairs, patient and public engagement policy replaced with Communication and Engagement Policy, change of name from Business centres to General Managers.	
Nov 2010		Annual review	

Ratified by: Trust Board

Date ratified: July 2008

Reviewed: November 2009

Reviewed by: IGAC on behalf of Trust Board

Next review date: Nov 2010

Target Audience: All staff, with particular reference for General Managers, Divisional Directors, Heads of Nursing, Matrons, Clinical Governance Leads, Executive Directors, and Non Executive Directors

Impact Assessment Carried Out By: Sarah Johnston, Head of Quality and Integrated Governance

Contact for Comments: Sarah Johnston, Head of Quality and Integrated Governance

ASHFORD & ST PETER'S HOSPITALS NHS FOUNDATION TRUST

Integrated Governance and Risk Management Strategy

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See also:

Risk Management Strategy for Women's Health
Information Governance Policy
Committee and Group Policy
Risk Assessment Policy
Reporting and Management of Incidents
Communication and Engagement Strategy

1. INTRODUCTION

The Integrated Governance and Risk Management Strategy incorporates the organisation's Integrated Governance process, the clinical governance process, and risk management, including clinical and non-clinical risk, and organisational risk.
The strategy should be read in conjunction with the Women's Health Risk Management Strategy and operational policies are referred to throughout the document where appropriate.

The strategy applies to all staff and senior staff in particular should ensure they have a good understanding of this document and ensure the processes are followed within their areas. The Trust will ensure that training is made available for all senior managers to support them in providing good risk management. The organisation recognises that the strategy and its implementation is key to good governance and safety and underpins the ability to give safe and effective care to our patients.

The organisation recognises that the process for governance and risk management in the NHS is constantly evolving. The Trust strives to continuously improve its processes, in line with key national guidance, to ensure safe, high quality services for our patients, and to provide a clear framework within which our staff can operate effectively. The organisation's Integrated Governance and Risk Management strategy reflects best practice, changes that are required nationally, and recommendations made following internal or external review, all of which are intended to improve our systems, and make the organisation more effective.

The achievement of Foundation Trust status demonstrates the improvement in risk management set out in the strategy 2008 – 2011. Going forward as a Foundation Trust requires the organisation to continue to maintain high standards, to embed the principles of risk management throughout the organisation including the Divisional structure, and to demonstrate high quality outcomes for patients and staff.

2. DEFINITIONS

2.1 INTEGRATED GOVERNANCE

Integrated Governance is defined as systems, processes and behaviours, by which Trusts 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, the wider community and future organisations.

Integrated Governance helps to rectify weaknesses in current systems of control. There is a clear obligation on the Trust Board to be satisfied that strategies, policies, sound systems and procedures are in place, are implemented and their effectiveness demonstrated. In order for the Trust Board to be assured, there needs to be a steady flow of targeted and specific information that fully informs the Trust Board, without overloading Board members with excessive and irrelevant details so that important information is not missed or difficult to find.

Integrated Governance should been seen as a co-ordinating principle, it does not replace clinical, financial or any other governance domain. Its purpose is to enable links to be made between all elements of governance, in order for the senior team to make balanced judgments and decisions based on risk to the relevant organisational purpose.

2.2 CORPORATE GOVERNANCE

The 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. The system will safeguard stakeholders' interests and the organisation's assets through effective systems of internal control which cover financial and operational management.

2.3 BOARD ASSURANCE FRAMEWORK (BAF)

The Assurance Framework provides the Trust with a simple but comprehensive method for the effective and focused management of the principal risks to meeting its objectives. It also provides a structure for the evidence to support the Statement on Internal Control. (Department of Health 2003).

2.4 STATEMENT ON INTERNAL CONTROL (SIC)

The Statement on Internal Control 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.

2.5 CLINICAL GOVERNANCE

Clinical Governance is a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish (Department of Health 1999).

It is both an individual and a collective responsibility, within a co-ordinated organisational control framework, for meeting and maintaining defined standards in respect of professional and clinical practice and patient safety. Clinical governance is about accountable care being provided in an open, questioning, just culture underpinned by organisational learning and improvement.

2.6 REGISTRATION

All health and adult social care providers who provide regulated activities are required by law to register with the Care Quality Commission. The organisation must monitor compliance with essential standards of Quality and Safety in order to assure itself that it is complaint with legislation.

2.7 QUALITY AND RISK PROFILE (QRP)

The QRP is a risk profile which the CQC provides for each organisation. It provides a risk rating for the essential standards of Quality and Safety, based on outcomes identified from a data set which the CQC compile. It provides an additional risk tool for the trust to consider where improvements need to be made.

2.8 ESSENTIAL STANDARDS FOR QUALITY AND SAFETY

The essential standards of quality and safety consist of 28 regulations (and associated outcomes) that are set out in two pieces of legislation: the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

For each regulation, there is an associated outcome. There are 16 essential standards that relate directly to quality and safety of care and it is the responsibility of the Trust to ensure compliance with these standards.

2.9 RISK MANAGEMENT

Risk management is a discipline designed to minimise the adverse effects of unwanted outcomes on an organisation's users and its human, physical and financial assets, through

- identification of risk
- measurement, analysis and prioritisation of risk
- control (prevention or reduction) of risk
- funding and insurance of risk

Corporate risk management covers risks which have an organisation wide impact on the provision of safe and effective patient care.

Clinical risk management covers the delivery of clinical care and associated systems and processes.

Non clinical risk (organisational) risk management covers the physical and organisational environment of care and is often closely associated with clinical risk management.

Financial risk management covers the financial systems and controls designed to safeguard the financial viability of the organisation.

Business and service risks covers risks associated with the Trust wide and local business planning process of any service change and / or development, and may comprise of clinical, non clinical or financial risks.

Hazards and Risks

A hazard is defined as something with the potential to cause harm, whilst a risk is defined as the likelihood that harm from a particular hazard may be realised.

Risk assessment is, therefore, the process of identification of hazards and the quantifying of the risk that such hazards might cause harm.

3. PURPOSE

This document provides the overarching framework for Integrated 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 risk to patients, staff and the organisation are managed effectively.

4. DUTIES AND RESPONSIBILITIES

4.1 STATUTORY RESPONSIBILITIES

The Trust is committed to meeting the requirements of corporate and clinical governance. The Chief Executive is the Accountable Officer for both corporate and clinical governance.

Boards of NHS organisations must meet a range of legal and further responsibilities required by the Department of Health. This includes duties identified in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009, and ensuring compliance with Health and Safety legislation.

Assurance Statements

- An annual Assurance Statement for financial controls is included in the Trust's Annual Accounts.
- A Statement on Internal control (SIC), signed by the Chief Executive on behalf of the Trust Board is required by the Department of health.

Stakeholder involvement

NHS organisations in line with all organisations need to comply with legislation and in particular the duty of partnership (to work in cooperation within the local healthcare community with other organisations such as the Local Authority, police, education) and the duty of patient and public involvement (the responsibility under Section 18 of the NHS Act to involve patients and local communities in all aspects of the planning, delivery and review of care services).
The Communication and Engagement Strategy sets out the organisations strategy to achieve this.

4.2 TRUST BOARD

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

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

4.3 CHIEF EXECUTIVE

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

4.4 EXECUTIVE DIRECTORS

The Executive Directors are responsible for the development of robust integrated governance arrangements for the Trust ensuring that systems and structures to meet statutory and legal responsibilities, which are based on good practice and guidance from the Department of Health, are in place.

4.5 DIRECTOR OF FINANCE AND INFORMATION

The Director of Finance has the following responsibilities:

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

4.6 CHIEF NURSE

The Chief Nurse has the following responsibilities

- Responsibility for ensuring effective corporate governance processes are in place (jointly with the Medical Director)
- Responsibility for ensuring adequate clinical governance systems and processes are in place (jointly with the Medical Director)
- Responsibility for ensuring that the Trust has a robust organisational risk management process in place, and that this works effectively.
- Responsibility for ensuring that there are systems in place for the management of clinical and non-clinical risk.
- Responsibility for ensuring that there are robust systems and processes to manage the assurance for Essential Standards of Quality and Safety and the NHSLA/CNST Risk Management Standards.
- Responsibility for ensuring Integrated Governance and Risk Management Strategy and Risk Management Strategy for Women's services is in place
- Executive Lead on the Trust Board for Maternity Services
- Executive Lead for Health and Safety

4.7 MEDICAL DIRECTOR

The Medical Director has the following responsibilities

- Responsibility for ensuring effective corporate governance processes are in place (jointly with the Chief Nurse)

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

4.8 DIRECTOR OF WORKFORCE AND ORGANISATIONAL DEVELOPEMENT

The Director of Workforce and Organisational Development has responsibility for the strategic development of the workforce and for ensuring adequate assurance and risk management is in place in line with statutory requirements

4.9 DEPUTY CHIEF EXECUTIVE

The Deputy Chief Exceutive has the following responsibilities

- Responsibility for ensuring the effective implementation of the strategy within the organisation's Divisions
- Responsibility for ensuring adequate risk management is evident within the Divisions

4.10 NON EXECUTIVE DIRECTORS

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

4.11 HEAD OF CORPORATE AFFAIRS

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

4.12 HEAD OF QUALITY AND INTEGRATED GOVERNANCE

The Head of Quality and integrated Governance has the following responsibilities

- Responsibility for the operational process for Integrated Governance
- Responsibility for the operational process for Clinical Governance

4.13 HEAD OF CUSTOMER AFFAIRS

The Head of Customer Affairs has the responsibility for the operational process for PAL's, Complaints and Clinical Claims

4.14 CLINICAL RISK MANAGER

The Clinical Risk manager has the following responsibilities:

- Responsibility for the operational process for management of risk
- Responsibility for the operational management of the Trust Risk register
- Responsibility for the Non-Clinical Claims process
- Responsibility for the operational management of incidents including Serious Untoward Incidents (SUI)

4.15 DIVISIONAL DIRECTORS/ ASSISTANT DIRECTORS/ GENERAL MANAGERS/ SENIOR MANAGERS/HEADS OF NURSING/HEADS OF DEPARTMENTS

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

4.16 WARD MANAGERS/ MATRONS/ SERVICE MANAGERS

Ward Managers, Matrons and Service Managers are responsible for the implementation of Trust policies and procedures. They are also are responsible for implementing systems that meet statutory requirements and control risks.

4.17 ALL STAFF

Have the responsibility to contribute to good Integrated Governance by complying with all Trust policies and procedures and reporting incidents and near misses. All staff are responsible for identifying risk, and either reporting this to their manager or putting the risk on the risk register. All staff should attend relevant mandatory training on risk management, patient safety and incident reporting.

5. INTEGRATED GOVERNANCE FRAMEWORK

5.1 INTEGRATED GOVERNANCE AND RISK MANAGEMENT STRUCTURE

The Integrated Governance and Risk Management Structure has three defined levels
Level 1, comprises of the four Committees which report directly to the Trust Board and have particular responsibility for providing assurance to the Board. A fifth committee, TEC, is the operational delivery committee and is also available to offer assurance to the Trust Board
Level 2, comprises of two committees, Clinical Governance Committee and the Safety and Risk Committee which provide assurance to the Integrated Governance Assurance Committee (IGAC), in relation to clinical services provision and delivery of standards, via the reporting Committees, Groups and Divisions.
Level 3, comprises of the Groups that are responsible for overseeing the various elements of the Trust services.

Appendix A Integrated Governance and Risk Management Structure

5.2 COMMITTEE AND GROUPS POLICY

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

5.3 INTEGRATED GOVERNANCE ASSURANCE COMMITTEE (IGAC)

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

The Committee will meet bi-monthly and has the following responsibilities:

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

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

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

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

- To receive a detailed report on Serious Untoward Incidents (SUI)

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

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

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

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

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

- Provide a six monthly report to the Trust Board describing the actions the Committee has taken to ensure review of risk.

The full list of reporting Committees is found in Appendix A

5.4 AUDIT COMMITTEE

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

The Audit Committee has the following responsibilities:

- To ensure there is an effective internal audit function; the Committee has the primary responsibility for the recommendations made by the external and internal Auditors.

- To report to the Trust Board and maintain direct links into the IGAC.

- To review the minutes of the IGAC, in order to discharge their duties as identified in the Audit Committee's Terms of Reference.

- To review the Corporate Risk register. The Committee has the authority to request further information around the corporate risks, or to request IGAC to review the corporate risk register, in light of any information the Committee has received

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

5.5 BOARD ASSURANCE FRAMEWORK (BAF)

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

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

Assurance Framework will be a dynamic document and controls, gaps in controls and progress against closing those gaps will be regularly reported to the Trust Board.
The Executive Director with lead responsibilities for the BAF is the Chief Executive.

The full BAF will be actively reviewed at the bi-monthly IGAC and presented to the Trust Board at each Trust Board meeting.

5.6 STATEMENT ON INTERNAL CONTROL (SIC)

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

5.7 INTERNAL AUDIT

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

5.8 EXTERNAL AUDIT

The external auditors are required to review the SIC with considerations as to whether the SIC has been prepared in line with the DoH requirements. The external auditors will identify any inconsistencies between the SIC and any information they are aware of in relation to financial arrangements. The auditors will also consider the governance arrangements in place.

5.9 CLINICAL GOVERNANCE COMMITTEE (CGC)

The CGC has responsibility for overseeing progress and assurance for clinical quality standards. Divisions will report to the CGC annually with a full report on clinical governance activities. The Committee will review Divisions risk registers at every bi-monthly meeting to provide input into action plans and progress and to ensure risks are appropriately mitigated. Where further actions are required, the committee will request an update on those actions at the next meeting or earlier if required.
The CGC has responsibility for overseeing the Committees or Groups shown under the CGC arm of the Integrated Governance and Risk Management structure (see Appendix A).

See Committee and Group Policy for full information on the reporting mechanism for CGC
http://trustnet/documents/menu152.htm

5.10 SAFETY AND RISK COMMITTEE

The S&RC has responsibility for overseeing the Committees or Groups shown in the safety and risk arm of the Integrated Governance and Risk Management structure (see Appendix A). The Committee will ensure adequate assurance is provided to IGAC to assure the Committee, Audit Committee and Trust Board that all regulation requirements are being met, or being actioned, where appropriate. The S&RC has responsibility for reviewing the organisation wide risk register and providing a level of scrutiny and support to ensure risks are appropriately mitigated and

actions are progressing. The S&RC has responsibility for considering the themes identified from incident reporting, and ensuring Directorate issues and learning relating to clinical incidents are shared across the Directorates and wider organisation. The committee will co-ordinate relevant benchmarking activities relating to key reports from the Care Quality Commission or National Patient Safety Agency (NPSA). The committee will ensure that risks identified by other safety committees are discussed and wider action taken if necessary. This will be co-ordinated by the Clinical Risk Manager.

See Committee and Group Policy for full information on the reporting mechanism for S&RC http://trustnet/documents/menu152.htm

6. PATIENT SAFETY

The services, treatment and care provided to adults and children needs to 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 incidents, near misses, concerns and unexpected outcomes. The Trust promotes a 'being open' and 'fair blame' policy. Information relating to the management of an incident including a Serious Untoward Incident (SUI) is in the Reporting and Management of Incidents policy.

Sharing of learning is an important element of patient safety management and by integrating risk management into all activities, promoting reporting, having open communication with patients and their relatives when thing go wrong, the Trust can share learning and implement changes in practice or instigate solutions to prevent further harm. The CGC and S&RC are the key committees for disseminating that learning. It is the responsibility of the Divisional Directors and General Managers to ensure appropriate clinical governance processes are in place in their directorate, and that adequate representation is made to the S&RC Committee in order to contribute to the organisation's risk management process.

6.1 MONITORING PATIENT SAFETY

Patient Safety is monitored through the following routes

- Divisions are required to provide evidence to the Clinical Governance Committee to demonstrate the team's effective management of patient safety and clinical risk. This is provided in the annual Divisional report.
- The key issues for each Division, learning from any grade 3, 4 or 5 incident, and learning from other incidents or positive action taken, is shared at the S&RC
- A six monthly report is provided to IGAC, which includes information, trends, and actions in place, in relation to PAL's, incidents, complaints and claims.

6.2 STANDARDS FOR PATIENT SAFETY

To ensure that patients receive treatment and care that is safe as is possible and of a high quality, the Trust will comply with the National Health Service Litigation Authority (NHSLA) and Clinical Negligence Scheme for Trusts (CNST) Risk Management Standards and the statutory requirements of the Care Quality Commission via the Essential Standards of Quality and Safety.

7. ESSENTIAL STANDARDS OF QUALITY AND SAFETY

The priorities reflected in the Essential Standards will be reflected in the key priorities of the organisation and the risk register should reflect relevant risks to achieving those priority goals. The organisation uses a web based tool called 'Performance Accelerator' to monitor current status. The nominated standard owners have responsibility for reporting the self assessment score to the executive lead quarterly, and the nominated executive lead has responsibility for ensuring status updates occur and is adequate to provide assurance to IGAC. The standard owners are required to consider any action plans needed to ensure continuous quality improvement.

The Quality and Risk Profile (QRP) will provide an additional tool to consider the level of risk to good patient outcomes. The monthly QRP will be provided to standard owners and General Managers to enable them to see where our key risk lie, to enable action to be implemented.

8. RISK MANAGEMENT

Within the NHS, '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.

Ashford & St Peter's Hospitals NHS Trust is committed to:

- Providing and safeguarding the highest standards of care for patients
- As far as reasonable practicable doing its best to protect patients, staff, the public and other stakeholders and the organisation's assets and reputation from the risks arising through its undertakings
- Minimizing risks associated with new developments 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

Ashford & St Peter's Hospitals NHS Trust has a duty to keep relevant stakeholders informed, and where appropriative to consult 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 be dependent up on the individual risk and the circumstances at the time,

8.1 RISK ASSESSMENT, IDENTIFICATION AND EVALUATION

8.1.1 RISK ASSESSMENT AND IDENTIFICATION

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

External scrutiny and inspections, such as

- Internal and External Audit Reports
- Accreditation Bodies Reports e.g. Royal Colleges, NHSLA, HSE, Environmental Health
- Care Quality Commission Reports

Occurrences such as

- Incident & Event Reporting (including near misses)
- Incidents
- Complaints
- Claims

Internal assessments and reviews such as

- Specialist Committees e.g. Infection Control, Health & Safety etc.
- Clinical and non clinical risk assessments, supported by the Risk Assessment Tool (RAT)
- Hazard and Alert Reporting e.g. Central alerting System
- Networking – use of media reports and information from other Trusts
- Workforce information analysis
- Monitoring of compliance with legislation and mandatory guidance
- Performance monitoring and service reviews
- Impact Assessments are undertaken on all new and reviewed policies to identify any risk to the organisations implementation of Equality legislation.
- Risk assessment and risk management forms part of the business planning process. Risk assessment is required for business cases and guidance is provided.
- See Business Case guidelines on trust net http://trustnet/departments/finance/Business%20Case%20Guidelines%20160609.pdf
- The risk assessment should include an Impact assessment to identify any risks relating to Equality and Diversity

8.2 SCORING OF RISK – RISK MATRIX

Appendix B Risk scoring Matrix

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

The Risk Matrix is a generic matrix, which is used to assess the full range of risks, i.e., clinical, non clinical, operational, strategic, and financial. The use of a risk matrix facilitates the identification of the level of the individual risk being considered. All risks are considered in terms of; how likely it is that the risk would occur (likelihood) and, if it did happen, what level of injury or damage is likely to be sustained (severity).

The Trust's 5 x 5 risk matrix is recommended by the National Patient Safety Agency.

8.3 SIGNIFICANT AND ACCEPTABLE RISK

The use of a risk matrix as a means of quantifying the likelihood of incidence and severity of identified risks provides a factual basis for helping to determine what constitutes an acceptable or significant risk. The following definitions are intended as a guide to action planning and decision making

Acceptable risks

Acceptable risks are those that achieve a score of between 1 – 6 (green and yellow) on the Trust's risk matrix.

These are risks that may occur rarely or routinely but which are minor in nature, with minimal financial loss, cause minimal damage to structure, equipment or property and would not cause serious harm, damage or loss to persons.

Risks which occur rarely and might cause serious harm, damage or loss (i.e. with a severity score of 4 or 5), but which would take disproportionate resources to eliminate or reduce, can be considered acceptable, but only with the agreement of the appropriate Executive Director.

Significant risks

Significant risks are those risks that achieve a score between 8 – 25 (orange and red) on the Trust's risk matrix.

These are risks which occur routinely or regularly and which would cause serious harm, damage or loss to persons or property. Those risks which occur rarely or very rarely but might cause death or very serious harm to persons, or potentially catastrophic damage or loss to property, income or reputation, would also be considered significant.
Risks which occur occasionally or routinely and might cause serious harm to persons, and which require significant resources to reduce or control

Other risks that may also be assessed as significant include commonly recognised risks for which the Trust's control measures would be deemed inadequate if benchmarked against comparable organisations, risks that would cause the Trust to fail or have serious difficulty in achieving its financial, performance or governance objectives, and risks which contravene statutory or mandatory requirements.

All extreme risks (scored at 15 - 25) will be reported to the relevant Director immediately that they are identified.

8.4 RISK REGISTER

The Risk Register is the Trust's record of the process of risk identification, analysis, evaluation, prioritisation and treatment process and is the basis for the Trust's risk management planning. The risk register is the repository for all identified risks. The risk register holds the local risk registers for the Divisions and service departments as well as the Corporate Risk Register.
The General Managers have the authority to place a risk on the risk register and are required to sign off each risk register notification form.

8.5 RISK REVIEW

Local Risk Register
Local risks are owned by General Managers, and departmental leads. Divisional Directors /Heads of Departments/Associate Directors/General Managers will receive, for review, their area's local risks on a regular basis. It is the responsibility of the General Manager to ensure review of their Divisional risks, including the risk score.
The local risk register is reviewed by CGC and S&RC.
New local risks and all high local risks are review by IGAC.

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

Appendix C Corporate Risk Register Process

The corporate risk register will be reviewed by the IGAC, at every meeting and subsequently reviewed by the Audit Committee quarterly. The corporate risk register will be viewed by TEC monthly and by Trust Board bi-monthly. The corporate risk register will be monitored and maintained by the Executive Directors.

The BAF
The full BAF will be reviewed at every IGAC meeting, and will be presented to the every other trust Board, following IGAC. The BAF will be received at least annually by the Audit Committee and can be requested by the Chair of Audit Committee at any time.

8.5 MANAGEMENT OF RISKS

Where a risk has been identified appropriate controls are put in place to mitigate or control the risk to an acceptable level. All identified risks are to have a treatment plan. There are four treatment plan options, called the 4 "T's"

- Tolerate — Accept the risk at its current level
- Transfer — Transfer the risk to another party, i.e., by outsourcing, the consequences of this action will require risk assessing
- Terminate — Stop the activity that presents the risk, the consequences of this action will require risk assessment
- Treat — Take action to reduce or mitigate the risk, in terms of reducing the likelihood of its occurrence or reducing the severity of impact if it does occur

8.6 ACHIEVIING RISK AWARENESS

To ensure risk management is effective throughout the organisation all staff need to be 'risk aware', at an appropriate level for their role within the Trust.
Mandatory training on risk assessment, patient safety, and incident reporting is provided for staff throughout the year. The risk managers will provide annual risk management training for the Trust Board and senior managers.

9. RESPONDING TO EXTERNAL AGENCY VISITS AND INSPECTIONS

The Trust is subject to a number of announced and unannounced inspection and accreditation visits or reviews from external agencies.

Once the Trust is aware of a forthcoming visit, an appropriate lead Director will be nominated to oversee the visit. The Lead Director will nominate a suitable lead manager or clinician to co-ordinate the visit and collate any feedback as a result of the visit

A central record of external visits is held in the Quality Department.

Where these visits result in recommendations for improvement, an action plan will be developed.

The lead manager will be responsible for developing and maintaining the action plan, ensuring regular reporting back to the Director and, where appropriate, to a designated committee. All actions on the action plans will have a review or completion date.

The lead manager should, where appropriate populate the Trust Risk Register with risks identified from the visits and inspections.

The lead Director will be responsible for ensuring the implementation and monitoring of any recommendations made as a result of external agency visits and inspections.

10. PATIENT AND PUBLIC ENGAGEMENT

The importance of ensuring patient and public involvement, and responsiveness and sensitivity towards the needs and wishes of patients, their families and carers will continue and be developed and embedded through the Trust's strategy for Communication and Engagement.

11. MEASURING PROGRESS

Performance indicators of the organisation's progress in managing risk and improving safety and quality will include:

The level of Divisional ownership and delivery, demonstrated at the clinical governance committee, and evidenced by

- Minuted regular Divisional meetings where clinical governance, safety, quality and risk are discussed
- The number of completed up to date risk assessments within the Division
- Recorded changes made in response to incidents, complaints, claims, risk assessments and audits within the Directorates

Demonstrable organisational improvement in the following areas:

- Increased incident reports, especially concerns and near misses, and increased reporting by doctors.
- Decreased serious incidents (Grade 3 or 4) on the same theme (e.g. fractures as a result of falls)
- Reduction in hospital acquired infection including MRSA Bactaraemias, Clostridium Difficile, Surgical Site Infections and other infections subject to national mandatory reporting.
- Maintained or improved NHSLA Risk Management Standards status
- Assurance of staff knowledge and competence as evidenced by attendance rates for Trust induction and mandatory training
- Rising level of staff safety awareness and confidence in Trust systems as evidenced by responses in the national staff survey.

13. MONITORING OF THE STRATEGY

The IGAC will monitor the implementation of this strategy and undertake an annual review and make any necessary changes and updates.
In addition, the effectiveness of the governance processes will be reviewed by the internal and external auditors and recommendations put forward in the annual reports.

14. DISSEMINATION AND IMPLEMENTATION

This policy will be made available on the Trust intranet. Directors, Divisional Directors and General Managers are responsible for ensuring that all staff are made aware of this policy's existence and receive specific training or instruction if appropriate.

15. ARCHIVE ARRANGEMENTS

This is a Trust wide document and archiving arrangements are managed by the Quality department.

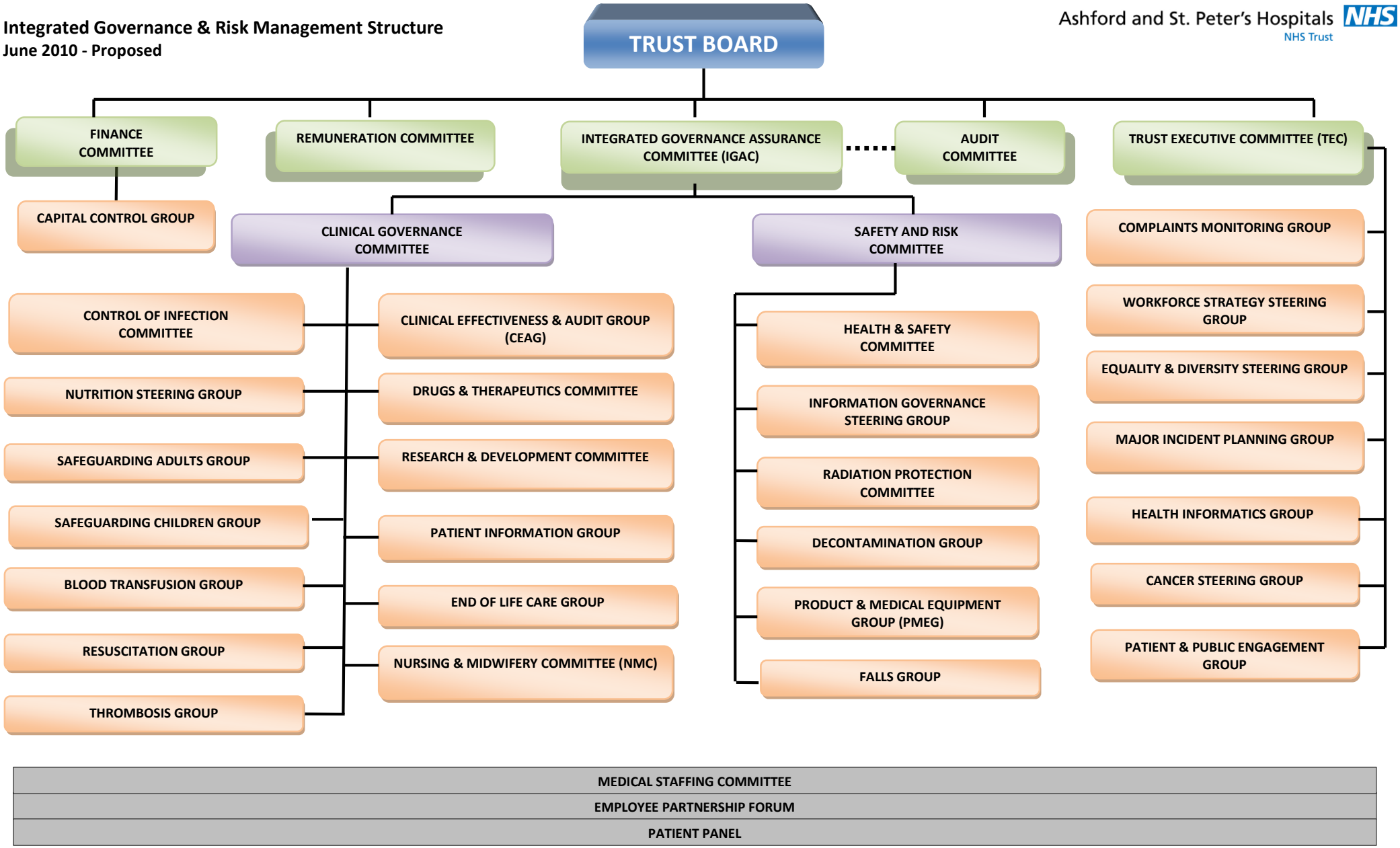
16. REFERENCES AND BIBLIOGRAPHY

Essential Standards for Quality and Safety (CQC publication March 2010) www.cqc.org.uk
NHS Litigation Authority Risk Management Standards for Acute Trusts (April 2008) www.nhsla.com
Clinical Governance in the new NHS Circular (Dept of Health 1999) www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4004883
Governing the NHS: A guide for NHS Boards (DH and NHS Appointments Commission, June 2003)
Integrated Governance (hfma (Healthcare Financial Management Association) handbook, 2007)
Integrated Governance Handbook (DH, February 2006)
The Intelligent Board (Dr Foster, February 2006)

APPENDIX A

Integrated Governance & Risk Management Structure
June 2010 - Proposed

Ashford and St. Peter's Hospitals NHS
NHS Trust



APPENDIX B Risk Scoring Matrix – Examples of Qualitative Measures of Severity [Consequence] of Risk

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

Qualitative Measures of Likelihood of Risk

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

Risk Matrix - Severity x Likelihood

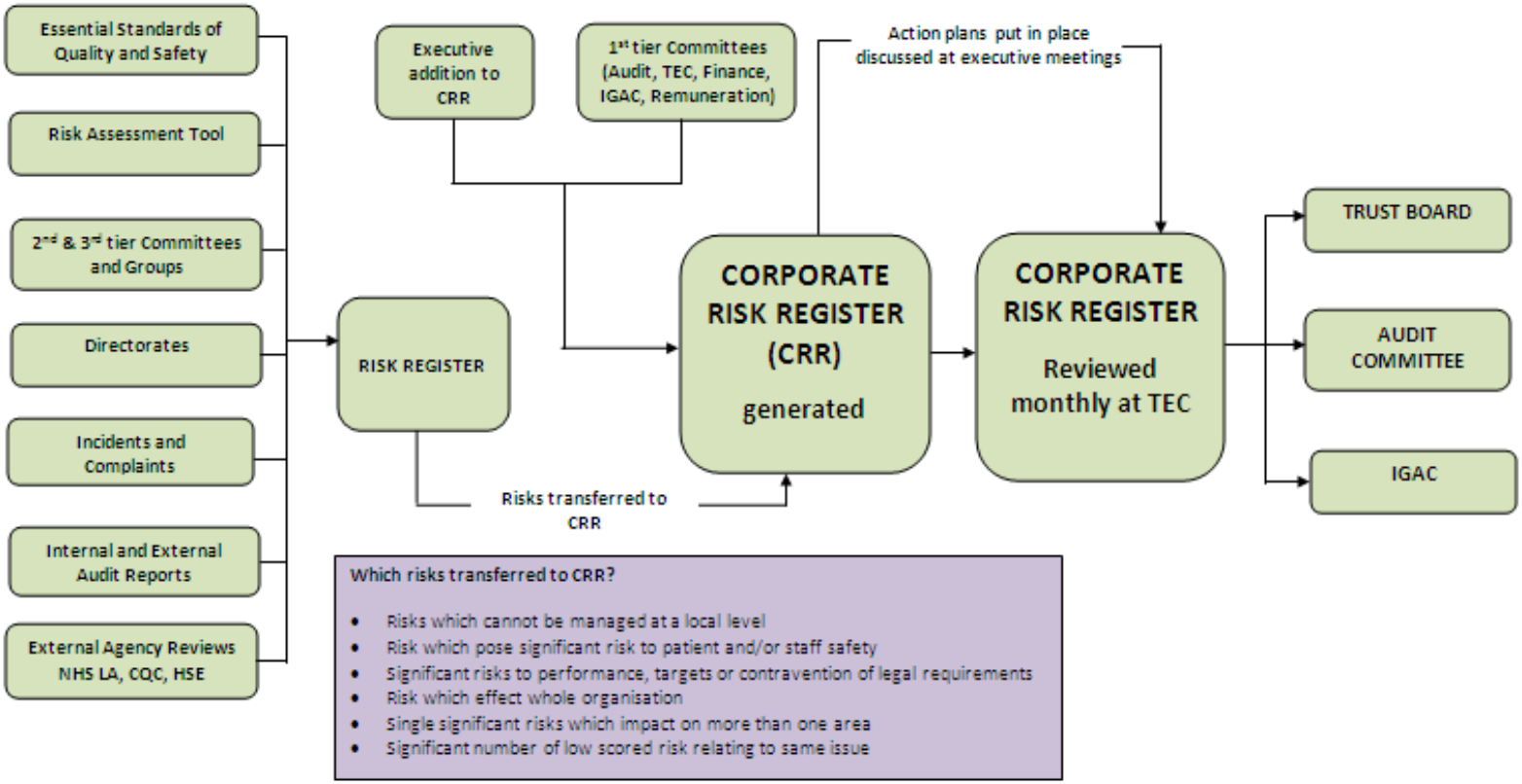
			Likelihood				
			Rare	Unlikely	Possible	Likely	Almost Certain
Severity	Descriptor		1	2	3	4	5
	Negligible	1	1	2	3	4	5
	Minor	2	2	4	6	8	10
	Moderate	3	3	6	9	12	15
	Major	4	4	8	12	16	20
	Catastrophic	5	5	10	15	20	25

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

APPENDIX C

Ashford and St. Peter's Hospitals NHS
NHS Trust

Corporate Risk Register Process



Equality Impact Assessment Summary

Name: Integrated Governance and Risk Management Strategy

Policy/Service: Quality Department

Background • Description of the aims of the policy • Context in which the policy operates • Who was involved in the Equality Impact Assessment
The strategy sets out the framework for governance within the trust and the process for risk management. The strategy is provided for all members of the trust and underpins excellent quality of care for our patients. The impact assessment has been carried out by the Head of Quality and Integrated Governance.
Methodology • A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age) • The data sources and any other information used • The consultation that was carried out (who, why and how?)
The strategy does not detail any direct care of patients and/or carers. Each item listed above has been given consideration in relation to how the policy would be implemented e.g. is there anything within the strategy that a member of staff from a BME background would have difficulty implementing.
Key Findings • Describe the results of the assessment • Identify if there is adverse or a potentially adverse impacts for any equalities groups
There are no adverse impacts identified for implementation of this strategy.
Conclusion • Provide a summary of the overall conclusions
The strategy does not relate to direct patient care, there are no adverse impacts identified for implementation of this strategy, and o further analysis is being taken forward.
Recommendations • State recommended changes to the proposed policy as a result of the impact assessment • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified • Describe the plans for reviewing the assessment
No recommendations made.

Guidance on Equalities Groups

Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)	**Religion or belief** (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)
Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)	**Sexual orientation including lesbian, gay and bisexual people** (consider whether the policy/service promotes a culture of openness and takes account of individual needs
Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)	**Age** (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)
Culture (consider dietary requirements, family relationships and individual care needs)	**Social class** (consider ability to access services and information, for example, is information provided in plain English?)