NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

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Integrated Governance Framework

Lead executive	Medical Director, Executive Director Lead for Quality
Authors details	Associate Director of Safe Services

Type of document	Policy
Target audience	All CWP staff
Document purpose	The integrated governance framework combines the high level risk management and performance management frameworks into one. This is to ensure that effective governance systems can be implemented, without unnecessary duplication, and the Trust can monitor and deliver its strategic objectives.

Approving meeting	Board of Directors	Date 25-Jul-18
Implementation date	09-Jul-20	

CWP documents to be read in conjunction with	
HR6	Mandatory Employee Learning (MEL) policy

Document change history	
What is different?	Updated to Appendix 1 – Trust Meeting Structures
Appendices / electronic forms	
What is the impact of change?	Providing further clarity to the operational working of the Trust.

Training requirements	No - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

Document consultation	
Clinical Services	Who within this service have you spoken to
Corporate services	Who within this service have you spoken to
External agencies	Who within this service have you spoken to

Financial resource implications	None

External references
1.

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Comments**
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	
- Nationality	No	

Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Comments
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	No	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
N/A		
Is the impact of the document likely to be negative? - If so can the impact be avoided? - What alternatives are there to achieving the document without the impact? - Can we reduce the impact by taking different action?	No N/A N/A N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

Contents

1. Introduction

The Integrated Governance Handbook, produced by the Department of Health (2006), remains relevant in the current and emerging care system landscape, describing integrated governance as *'systems, processes and behaviours by which Trusts lead, direct and control their functions, in order to achieve organisational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organisations'*.

Integrated governance in Cheshire and Wirral Partnership NHS Foundation Trust (CWP) is therefore about the integration of clinical and corporate governance, clinical and non-clinical risk management, and performance management/ improvement/ escalation processes in order to give the Board of Directors and key internal/ external stakeholders assurance regarding the quality and safety of the services that the Trust provides.

This ensures that effective systems are implemented without unnecessary duplication and the Trust can monitor and deliver its strategic objectives, which are as follows:

- Deliver high quality, integrated and innovative services that improve outcomes;
- Ensure meaningful involvement of service users, carers, staff and the wider community;
- Be a model employer and have a caring, competent and motivated workforce;
- Maintain and develop robust partnerships with existing and potential new stakeholders;
- Improve quality of information to improve service delivery, evaluation and planning;
- Sustain financial viability and deliver value for money;
- Be recognised as a progressive organisation that is about care, well-being and partnership.

2. Implementation of the integrated governance model

The delivery of this integrated governance framework relies on having:

- Robust internal (corporate) assurance mechanisms and quality governance arrangements – this is delivered through the direct and indirect assurance provided through the corporate meetings structure to the Board and to external stakeholders, i.e. regulators, commissioners, external scrutineers, partner organisations and engagement groups;
- Assurance mechanisms through the use of external and internal (independent) audit and seeking to review benchmarking/ peer review data, where available;
- Robust accountability arrangements that ensure actions will be taken should risk/ performance issues be judged as requiring escalation.

2.1 Corporate meetings structure

The Trust's corporate meetings structure is shown in appendix 1.

The committees of the Board, comprising non-executive, executive and integrated committees, are responsible for overseeing strategic risks outlined within the strategic risk register and corporate (Board) assurance framework. The Quality Committee reviews the strategic risk register at each meeting, as the committee with 'overarching responsibility for risk'. The Quality Committee will refer any risks to the Operational Committee as appropriate, particularly where there are identified resource requirements to address the risk/s. The Operational Committee also reviews risks referred by its sub groups, and monitors and reviews Care Group risk registers.

The Audit Committee is responsible for oversight and internal scrutiny of risk systems and processes within the organisation, and discharges these functions through the use of internal and external auditors. The internal audit plan is developed in collaboration with the strategic risk register. In addition, the Audit Committee receives the strategic risk register and corporate assurance framework on a quarterly basis to enable them to undertake periodic reviews of risk treatment processes for individual risks on an escalation/ enquiry basis. In summary, this committee provides additional assurance on risk management processes and systems for the Board of Directors.

The committees of the Board will escalate to the Board of Directors any risks where controls are not sufficiently impacting (positively) on the residual risk rating towards achieving the target risk score.

There must be approved, documented terms of reference for the high level committee/s with overarching responsibility for risk. The terms of reference for these, i.e. the Quality Committee, Operational Committee and Audit Committee are outlined in appendix 2 respectively.

Terms of references within the governance structure must include a description of:

- Duties;
- Who the members are, including nominated deputies where appropriate;
- How often members must attend;
- Requirements for a quorum;
- How often meetings take place;
- Reporting arrangements into the high level risk committee/s;
- Reporting arrangements into the Board from the high level risk committee/s.

2.2 How the board reviews the organisation-wide risk register

The corporate assurance framework is utilised by the Board of Directors as a planned and systematic approach to the identification, assessment and mitigation of the risks that could hinder the Trust achieving its strategic objectives. The assurance framework document contains information regarding internal and external assurances that strategic objectives are being met.

Where risks are identified, mitigations and subsequent action plans are mapped against them. The assurance framework is used to develop the risk register that is scored using a 5x5 matrix that multiplies an impact score by a likelihood score, see appendix 3 for risk matrix. The total score generated is known as the risk rating.

In addition to the escalation of risks via the committees of the Board, the Board of Directors is also required to receive the full corporate assurance framework document and the strategic risk register a minimum four times yearly for review.

The approved strategic risk register includes the following:

- Source of the risk;
- Description of the risk;
- Identified risk owner and risk leads;
- Risk score detailing inherent score (gross - before the application of controls), residual score (net - after the application of controls) and target (tolerable) score;
- Controls, assurances and risk treatment plan to address gaps;
- Date of review.

Each risk is linked to a Trust strategic objective and has an Executive lead responsible for seeking and receiving assurance that the actions required to mitigate the risk are completed at local, operational or strategic level.

2.3 Process for the management of risk locally, which reflects the organisation-wide risk management strategy/ how risks are escalated through the organisation

Risk is managed throughout the organisation at all levels, both up and down the organisation.

As well as having a strategic risk register, each Care Group has its own risk register/s which document speciality/ sub specialty risks identified by service line business and governance meetings, and locality risks identified by locality based governance meetings, with the accountable officers for risk management being the Strategic Clinical Director and Associate Director of Operations. The Care Group risk register must be monitored and reviewed by the Quality, Governance & Effectiveness meeting within the clinical services governance structure. Meetings within the corporate meetings structure or other meetings such as task and finish groups may maintain a risk log, but in doing so should at each meeting consider whether those risks that are logged represent a hindrance to the Trust achieving local/ place based objectives/ deliverables or Trustwide strategic objectives – the process of local management of risk and escalation should be followed as per Table 1. Additionally, corporate departments may also maintain departmental risk registers or risk logs, which are reviewed at least annually by the Medical Director (Executive Lead for Quality) and the Associate Director of Safe Services. The same process of escalation as described in Table 1 applies.

Risks can be managed and monitored at a clinical and corporate level, but must be escalated appropriately, dependent on the severity of the risk. This scheme of delegation is outlined below:

Table 1: Management of risk and escalation

Score	Grade	Clinical service management of risk and escalation	Corporate management of risk and escalation
Risk Rating 1 – 6 'Green'	**Low – moderate**	**Risk can be managed within clinical services via agreed governance structures** – individual/ team must escalate to Team Manager	**Risk can be managed via corporate services risk registers and/ or via risk log of meetings within the Trust meetings structure**
Risk Rating 8 – 12 'Amber'	**High**	**Risk can be managed within clinical services via agreed governance structures** – Head of Operations must escalate to Associate Director of Operations and Strategic Clinical Director	**Risk can be managed via corporate services risk registers and/ or via risk log of meetings within the Trust meetings structure**
Risk Rating 15 – 25 'Red'	**Extreme**	**Risk is escalated to Safe Services Department for consideration for inclusion on the strategic risk register. Those risks scoring 15 or more when modelled for their Trustwide impact are included and a risk treatment plan agreed** – Associate Director of Operations or Strategic Clinical Director to inform Safe Services Department. Safe Services Department to escalate to relevant Executive/s to agree	**Risk is escalated to Quality Committee for consideration for inclusion on the strategic risk register. Those risks scoring 15 or more when modelled for their Trustwide impact are included and a risk treatment plan agreed** – Quality Committee agrees Trustwide impact, with management in line with corporate assurance framework processes if risk score remains red

Score	Grade	Clinical service management of risk and escalation	Corporate management of risk and escalation
		Trustwide impact, with management in line with corporate assurance framework processes if risk score remains red.	

2.4 Assignment of management responsibility for different levels of risk within the organisation / authority levels for managing different levels of risk within the organisation

The integrated governance framework sets out the responsibility and roles of each level of leadership in the organisation in relation to handling and managing risk.

At an executive level, the Chief Executive has delegated operational responsibility for oversight of risk management processes to the Medical Director (Quality), but each Executive Director is accountable for managing the strategic risks that are related to their portfolio. Executive Directors, as strategic 'risk owners', can discharge accountability to 'risk leads' within their portfolio, e.g. Associate Directors/ senior managers.

At a Care Group level, Strategic Clinical Directors and Associate Directors of Operations are the accountable officers for the risk register process and must manage risks as outlined in section 2.3. Strategic Clinical Directors and Associate Directors of Operations, as local 'risk owners', can discharge accountability to 'risk leads' within their portfolio, e.g. Heads of Operations/ Heads of Clinical Services/ Matrons. As per section 2.3, any red rated local risks must be escalated to the Safe Services Department, for consideration to include on the strategic risk register. The Head of Clinical Governance will receive an automated notification from the Trust Datix system outlining that a risk has been red rated. The Head of Clinical Governance will highlight the risk to the appropriate Executive Director for consideration of inclusion on the strategic risk register; the Executive Director should consider the following factors:

- The impact of the risk on the organisation's ability to achieve strategic objectives;
- The nature of the risk (i.e. risks that could cause serious harm to people who access services);
- Does the risk treatment plan provide adequate assurance to mitigate the impact of the risk;
- If this risk is a place based risk or affects one or more services.

The Executive Director will indicate those risks that should be escalated to the strategic risk register; such decisions will then be reported to the next Quality Committee for approval.

2.5 How all risks are assessed

There are five steps to risk assessment as defined by the Health & Safety Executive, which the Trust has adapted, thus.

The approved strategic/ Care Group risk register includes the following:

- Source of the risk (including, but not limited to incident reports, risk assessments, locality risk registers, and external recommendations);
- Description of the risk;
- Identified risk owner and risk leads;
- Risk score detailing inherent score (gross – before the application of controls), residual score (net – after the application of controls) and target (tolerable) score;
- Controls, assurances and risk treatment plan to address gaps;

- Date of review.

The process for assessing and recording risk both at a strategic and locality level within the Trust is as follows:

Step 1 – Identify the hazards/ risks
This may be via a concurrent or reactive process (risk identified as a result of an incident for example) or via a proactive process (risk identified via a service development initiative/ clinical strategic priority). The source of the risk must be identified and recorded on the relevant (strategic/ Care Group) risk register.

Step 2 – Describing the risk and looking at current controls and assurances in place
Controls and assurances are recorded on the risk register and this helps determine the inherent (gross score) current residual risk score and target (tolerable) score (step 3).

Step 3 – Scoring the risk using 5x5 impact and likelihood
The risk is scored using the matrix in appendix 3.

Step 4 – Record of findings and actions
Actions are identified and implemented to reduce the risk to an acceptable level (as it is recognised that not all risks can be practicably be eliminated). An acceptable level of risk will be determined on a case by case basis (using the Trust's risk tolerance methodology) to formulate the target risk score.

Step 5 – Reviewing the risk at regular intervals

Care Group risk registers are reviewed monthly at the Quality, Governance & Effectiveness meetings to ensure that risks are being monitored/ managed. The strategic risk register is reviewed as a minimum four times per year by the Board of Directors and at every meeting of the Trust's Quality Committee which meets every two months. Outside of these meetings, where a new risk is identified or current risk controls are identified as not bringing about the desired degree of mitigation (i.e. occurrence of a further incident relating to a risk that is being managed) the Executive lead would identify the risk and ensure this is recorded on the strategic risk register and is escalated to the next Board of Directors meeting and Quality Committee.

2.6 How risk assessments are conducted consistently

There is not an exhaustive list of risk assessments however all risk assessments would usually follow their accompanying template, e.g. there is a stress risk assessment tool for stress, however where guidance is required to ensure a consistent approach to robustly conducting risk assessments for where there is not an accompanying tool, the Trust has also developed a generic risk assessment tool.

2.7 Risk awareness training for senior managers

As part of the Board of Directors development, there is regular risk management training to the Board of Directors and senior managers, both bespoke and as part of the Trust's Training Needs Analysis (TNA).

Trustwide risk awareness training sessions will be delivered as part of the mandatory employee learning programme and can be booked through the booking processes for training, outlined within Trust policy Mandatory Employee Learning (MEL) policy.

The process for recording attendance for the Board is via the Head of Corporate Affairs recording attendance and forwarding to Education CWP so that this can be recorded on the Trust's Electronic Staff Record (ESR) system. For all other attendees who must have risk awareness training, the recording of attendance is completed by Education CWP once the individual attends the learning event and signs the attendance register. Education CWP collates the sheets (either locally or through the trainer sending the documentation to Education CWP). The individual's learning record is updated by Education CWP to 'completed' or 'Did Not Attend' (dependent on the action) on ESR.

Follow-up of non attendance of Board members is undertaken by the Head of Corporate Affairs and, where a Board member has not been able to attend the planned seminar on risk management, where appropriate they will be booked onto one of the other senior managers risk awareness sessions planned as part of the Mandatory Employee Learning (MEL) programme.

Follow-up of non attendance for all other senior managers who must have risk awareness training (other than Board members) is undertaken as per the processes outlined within Trust policy Mandatory Employee Learning (MEL) policy.

2.8 Risk acceptance

No organisation can achieve its strategic objectives without taking risk. Each organisational strategic objective in the corporate assurance framework features risks which the organisation is engaging with

at any one time, which is indicative of the Trust's risk appetite. The risk tolerance is indicated by a target risk score in the corporate assurance framework, which is the level of risk that the organisation can accept.

As part of annual business planning cycle processes, including considering an integrated governance framework that incorporates local, regional and national strategic context, commissioning intentions, and horizon scanning information, the Board of Directors in accepting new risks to organisational strategic objectives will assess (through its receipt, review and approval of the corporate assurance framework) its appetite for the risk(s). Where the risk appetite scores 2 – 5, then the risk will be added to the corporate assurance framework, risk treatment plan identified, and a target risk rating allocated. As per the descriptions below, the assessment of the target risk will predominantly be influenced the likelihood score.

Risk Appetite	Assessment	Description
1	Zero	Organisation is **not willing to accept under any circumstances risks that may** result in reputation damage, financial loss, or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and/ or legislative compliance, potential risk of injury to staff/ people who access the Trust's services.
2	Low	Organisation is **not willing to accept (except in very exceptional circumstances)** risks that may result in reputation damage, financial loss, or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and/ or legislative compliance, potential risk of injury to staff/ people who access the Trust's services.
3	Moderate	Organisation is **willing to accept some risks in certain circumstances that may** result in reputation damage, financial loss, or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and/ or legislative compliance, potential risk of injury to staff/ people who access the Trust's services.
4	High	Organisation is **willing to accept risks that may** result in reputation damage, financial loss, or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and/ or legislative compliance, potential risk of injury to staff/ people who access the Trust's services.
5	Very high	Organisation **accepts risks that are likely** to result in reputation damage, financial loss, or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff/ people who access the Trust's services.

2.9 Escalation framework (incorporating judgement and accountability framework)

The integrated governance framework describes risk "events" and the management and escalation of these risks. However, as an integrated governance framework that not only considers risk but clinical governance and performance issues, consideration must also be given to the escalation of such "issues" that the organisation will be required to judge the significance of at any one time to inform means of escalation, for example to the Executive Team. The National Patient Safety Agency (NPSA) describes these in terms of the following domains:

- Impact on the safety of patients, staff or public;
- Quality/ complaints/ audit;
- Human resources/ organisational/ development/ staffing/ competence;

- Statutory duty/ inspections;
- Adverse publicity/ reputation;
- Business objectives/ projects (including local key performance indicators);
- Finance, including claims;
- Service/ business interruption;
- Environmental impact.

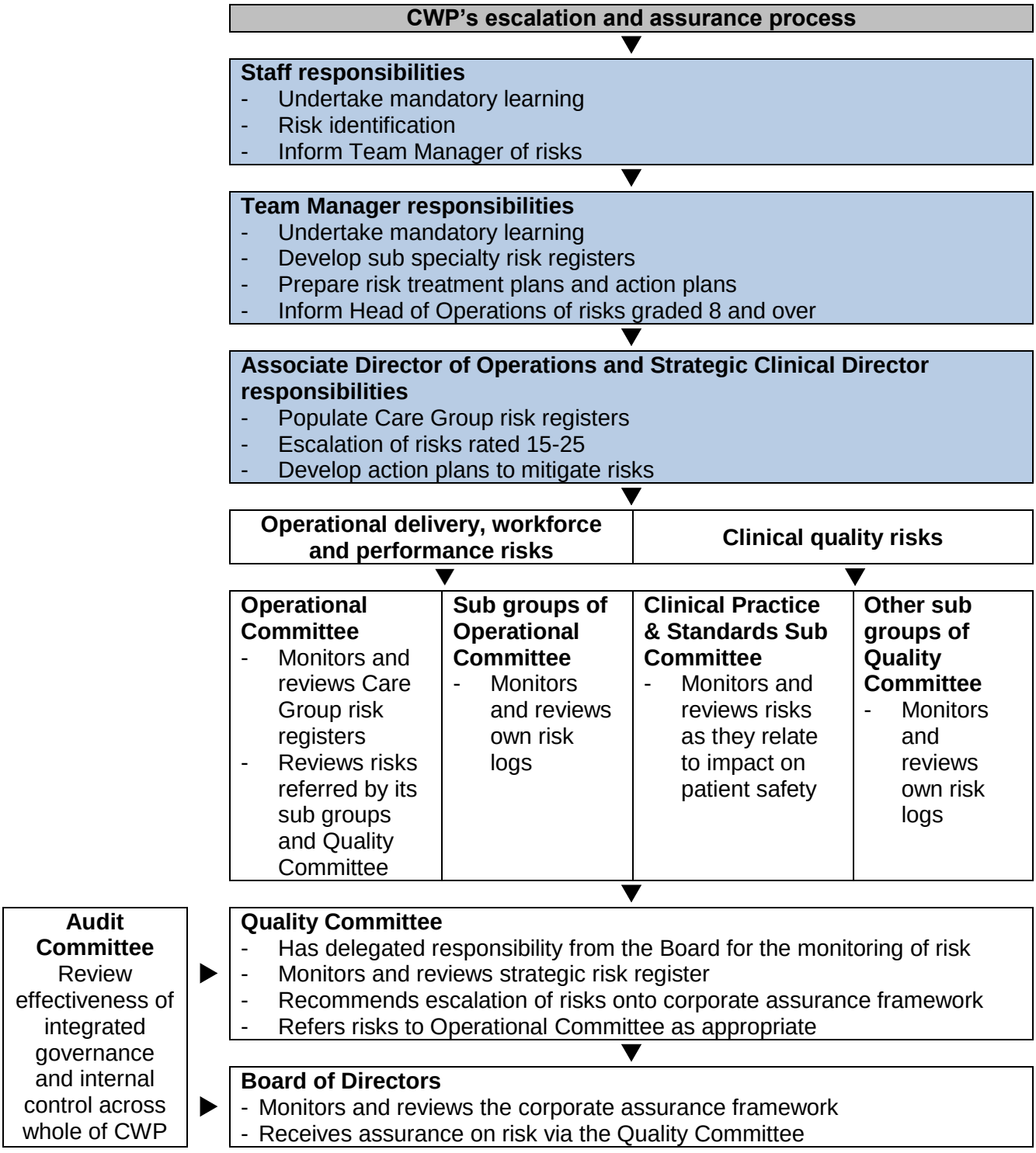
2.9.1 Early warning frameworks

The Board achieves 'ward to board assurance' by applying the integrated governance framework, which is designed to support the improvement to safety and quality on a continuous basis. In describing the Trust's escalation and assurance process, setting out the key responsibilities of individuals and key supporting committees, and being underpinned by the use of information and measurement, the framework enables and assure that safety and quality can be progressed and monitored at all levels from the 'ward to board'. Early warning frameworks are in place to identify the potential for deteriorating standards in the quality of care related to the above domains. For example, the corporate performance dashboard and quality assurance dashboard incorporates sets of indicators that, taken together, give an indication of how well an individual team or service is functioning. It provides an early warning, pre-empting more serious concerns and enabling action to be taken before things go wrong. It offers a simple method to enable clinical management staff to assess the risk of deteriorating performance and to benchmark against others. Other frameworks/ reports are reviewed by the Trust's Board of Directors to give a detailed view of CWP's overall performance, including:

- **The three times yearly Learning from Experience report** – reviews learning from incidents, complaints, concerns, claims and compliments, including *Patient Advice and Liaison Service* (*PALS*) contacts;
- **The quarterly Infection Prevention and Control report** – reviews the management and clinical governance systems in place to ensure that people experience care in a clean environment, and are protected from acquiring infections;
- **The three times yearly Quality Improvement Report** – provides a highlight of what CWP is doing to continuously improve the quality of care and treatment that its services provide.

2.9.2 Escalation

Clear, transparent and consistent use of evidence-based means of assessing/ judging these issues is essential to inform when and how to (including who to) escalate. Application of a consistent methodology also ensures means of applying ongoing judgements to inform eventual de-escalation. The risk rating matrix (appendix 3) provides criteria for scoring the risk associated with the above domains, and the significance of the risk. This facilitates the judgement of risk events or issues and whether they present as triggers for escalation. The following flowchart describes CWP's escalation and assurance process:



2.9.3 Trust meetings structure – reporting, responsibility, assurance mechanisms, escalation and accountability

The escalation framework is reliant on an effective Trust meetings structure (see appendix 1) which links through to the corporate assurance framework, underpinned by regulatory requirements. This provides the Board with assurance about how the organisation is able to identify, monitor, escalate and manage concerns, which may include identifying consequences to ensure performance management where assurance is not provided, in a timely fashion at an appropriate level.

The Trust's strategic plan is implemented, monitored and assured by the Trust's meeting structure which has delegated responsibility from the Trust Board. The structure monitors compliance through performance indicators, a comprehensive healthcare quality improvement programme, the monitoring of associated risks, and through other mechanisms of assurance. The table below demonstrates the reporting and accountability mechanisms.

These are supported by clear terms of reference (ToR) (the most recent ToR are available via the corporate governance manual) and responsibilities (appendix 1).

	Committees of the Board				Subsidiary Committees and Groups		
	Quality Committee	**Operational Committee**	**Audit Committee**	**Other Committees of the Board**	**Sub Committees**	**Groups**	**Task & Finish Groups**
Reporting to	Board				Board Committees	Sub Committees	Groups
Reviewed	Annually against ToR				Annually against ToR	Annually against ToR	On establishment
Membership	Non-Executive Directors, Executive Directors, Senior Managers, Senior Clinicians	Executive Directors, Senior Managers, Senior Clinicians,	Non-Executive Directors, Executive Directors, Senior Managers	Non-Executive Directors (for Non-Executive Committees) Non-Executive Directors and Executive Directors (for integrated committees)	Executive Directors Senior Managers Staff representatives	Various staff	Various staff
Responsible for	Strategy, Assurance, Monitoring progress, including identification of consequences, Devising plans	Strategy, Assurance, Monitoring progress, including identification of consequences, Devising plans	Strategy, Assurance, Monitoring progress, including identification of consequences, Devising plans	Assurance, Monitoring progress, including identification of consequences	Providing assurance, Implementing plans, Performance management of groups, including identification of consequences	Operational activity delivery	Specific delivery of work streams
Assurance mechanisms	Minutes, Action Log, Action Plans, Assurance/ improvement reports, Risk Registers	Minutes, Action Log, Action Plans, Assurance/ improvement reports, Risk Registers	Minutes, Action Log, Action Plans, Assurance/ improvement reports, Risk Registers	Minutes, Action Log, Action Plans, Assurance/ improvement reports	Minutes, Action logs, Action plans, Assurance/ improvement reports, Risk Registers	Minutes, Action log, Assurance/ improvement reports	ToR, Minutes, Action plans
Escalation of risks	To Board through strategic risk register, minutes, Chair's reporting, detailed assurance/ improvement reports	To Quality Committee through strategic risk register To Trust Board through minutes, detailed assurance/ improvement reports	To Trust Board through minutes, detailed assurance reports	To Board, via minutes and detailed assurance reports	To sub committee via minutes, risk registers, detailed assurance reports	To committees, reporting progress, risks, and quality	Report risks

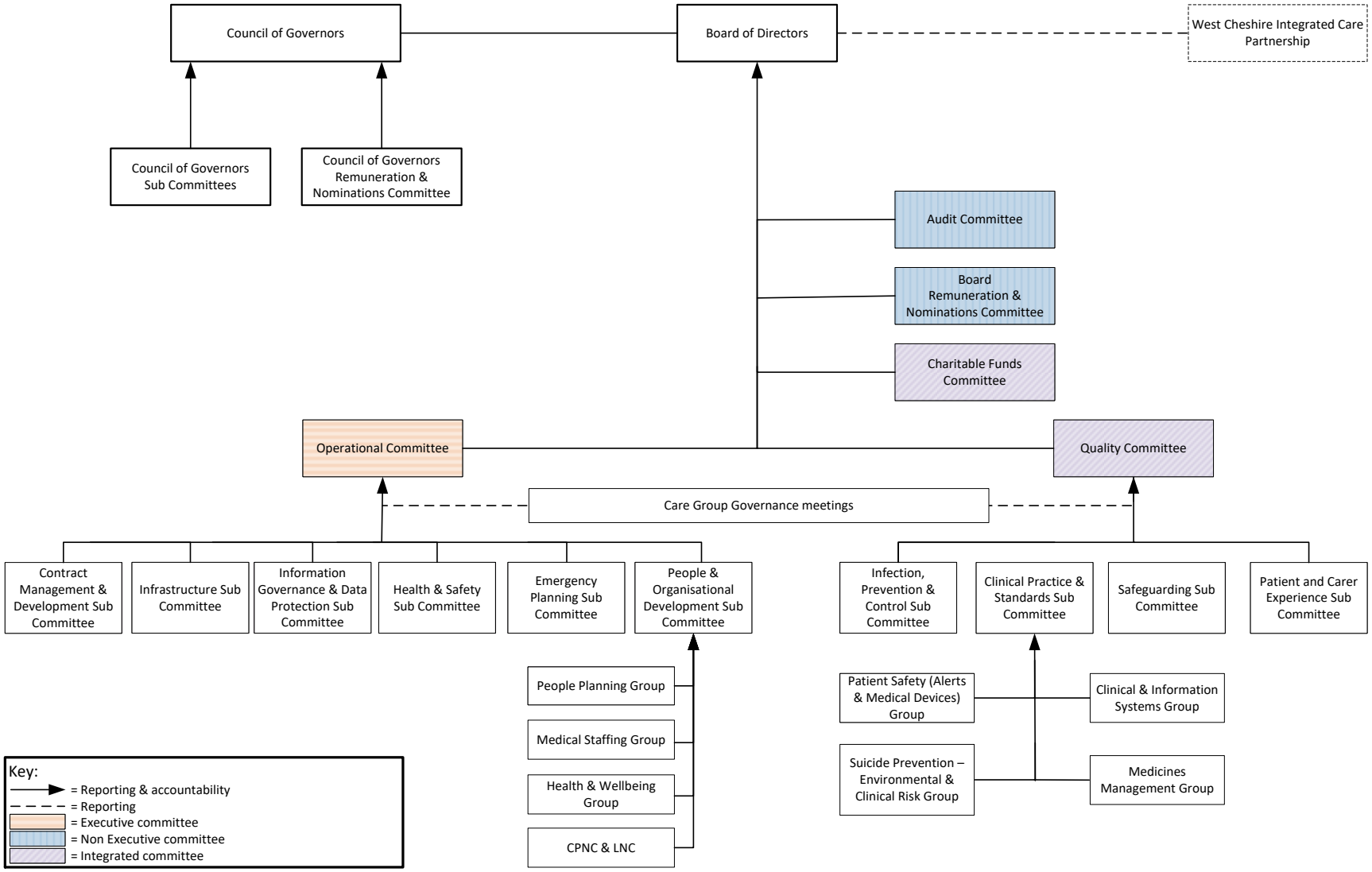
It is recognised that there will be times when urgent decisions are required outside of scheduled meetings. Such decision making authority by the Chair of the meeting on behalf of the group will only be used when an urgent decision is required and there are no alternatives (e.g. the matter will not wait

until the next meeting of the committee/ sub committee and cannot be managed in another way without introducing unwarranted risk). Anyone putting forward an item for Chair's action should ensure that the issue has been supported by key individuals and groups in the usual way.

To ensure transparency, any urgent decisions will be submitted, along with relevant supporting papers, to the next regular meeting for formal endorsement and documentation in the minutes. If decisions have an immediate impact on the wider membership of the group or an immediate impact on practice, the members will be informed as soon as is practicable.

Appendix 1 – Trust meetings structure

Trust meetings are also supported in their work through various clinical, professional, and multi-disciplinary networks and fora



Appendix 2 – Responsibility of committees

Operational Committee

The Operational Committee is responsible for ensuring that governance, assurance and improvement systems operate effectively and thereby underpin clinical care:

Assurance

Receiving assurance on performance through the lens of:

- People
- Clinical services
- Clinical support services
- Finance

Improvement

Overseeing delivery of strategic priorities as described in the CWP Forward View, in order to assure the Board of Directors that there is sustainable leadership, governance and improvement capability to deliver better outcomes for populations the Trust serves.

Operational Committee is the formal route to support the Chief Executive in effectively discharging their responsibilities as Accountable Officer.

The agenda for Operational Committee meetings will be structured to allow time for strategic debate and discussion of current and future issues affecting the Trust and the wider health care system.

Quality Committee

The Quality Committee is responsible for:

Assurance

Receiving assurance on organisational quality governance and current performance regarding quality of care.

Improvement

Ensuring that that the strategic priorities for quality improvement are identified, implemented and monitored, to support future planning including responding proactively to new care delivery models.

The Quality Committee has delegated responsibility from the Board of Directors for oversight of the integrated governance framework, has overarching responsibility for risk, and therefore for monitoring strategic risks within the organisation.

Audit Committee

The Audit Committee is responsible for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievements of the Trust's objectives. It will provide an independent and objective view on internal control and probity. In addition, the Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance, reviewing significant financial reports and the judgements contained in them.

Appendix 3 – Risk rating matrix

	Impact				
Likelihood of occurrence	**Catastrophic (5)**	**Major (4)**	**Moderate (3)**	**Low (2)**	**Minimal (1)**
Almost certain (5)	25	20	15	10	5
Likely (4)	20	16	12	8	4
Possible (3)	15	12	9	6	3
Unlikely (2)	10	8	6	4	2
Rare (1)	5	4	3	2	1

Some examples of scoring the impact of risks are outlined below:

	1	**2**	**3**	**4**	**5**
Descriptor	**Minimal**	**Low**	**Moderate**	**Major**	**Catastrophic**
Injury to staff or patient	Minor injury or illness, with/ without first aid treatment	NPSA reportable Police reportable (Violent & Aggressive acts)	Injury up to 24hrs hospital treatment required (except major injuries)	Major injuries Long term incapacity/ disability requiring extensive rehabilitation	Death or incident causing such harm that they place a patient or staff members life in jeopardy
Patient experience/ complaints	Concerns raised/ referral to PALS with agreed local resolution	Green complaint	Amber complaint	Red complaint	Detrimental recommendation following referral to external regulator
Litigation	None/ minor out of court settlement	Civil Litigation – without defence Litigation cost <£50k	Civil/ Criminal Litigation without defence costs of £50k - £500k	Civil/ Criminal Litigation without defence cost £500k - £1m	Litigation cost >£1m
Service/ Business continuity	Partial loss of service – short recovery	Partial loss of service – long recovery	Partial loss of service – cannot recover Complete loss of service – short recovery	Complete loss of service – long recovery	Complete loss of service – cannot recover
Staffing/ Capacity	Short term low staffing level temporarily reduces service quality (less than 1 day)	On-going low staffing level reduces service quality	Late delivery of key objective/ service due to lack of staff/ capacity	Uncertain delivery of key objective/ service due to lack of staff/ capacity within organisation	Non delivery of key objective/ service due to lack of staff/ capacity within organisation

	1	2	3	4	5
Descriptor	**Minimal**	**Low**	**Moderate**	**Major**	**Catastrophic**
Financial (Loss)	Less than £1k	More than £1k but less than £25k	More than £25k but less than £100k	More than £100k but less than £1m Drop in financial risk rating	More than £1m unrecoverable financial loss by end of financial year Drop in financial risk rating
Inspection/ Self-assessment	Minor recommendations Minor non-compliance with standards	Recommendations given. Non-compliance with standards	Critical report Challenging recommendations Non-compliance with standards	Enforcement Action. Severely critical report. Major non-compliance with standards	Successful prosecution De-authorisation by Regulator
Adverse publicity/ Reputation	Local media – Short term. Minor effect on staff morale	Local media – Long term Significant effect on staff morale	National media less than 3 days	National media more than 3 days Questions in Parliament	Public enquiry Prolonged national media attention

Measures of Likelihood are outlined below:

	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not