

RISK MANAGEMENT STRATEGY

November 2004

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**RISK MANAGEMENT
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Replaces January 2004**AUTHOR: RISK MANAGER****PAUL PHOENIX****REFERENCES: DEVELOPING AN ASSURANCE FRAMEWORK IN PRIMARY CARE**
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6.1 INTRODUCTION

Bolton Primary Care Trust (the Trust) is fully committed to providing high quality, appropriate and accessible healthcare to the people of Bolton. The Trust holds the well being of its staff, patients and visitors as a priority. As such the Trust recognises that managing risks in all areas wherever reasonably practicable is an imperative and is in line with the organisation's corporate and strategic aims

The Trust is fully committed to effectively managing clinical and non-clinical risks and will ensure that appropriate risk management systems, procedures and arrangements are implemented.

The purpose of these systems is to identify, control, eliminate or reduce to an acceptable level, all risks (*the chance of something happening*) that may adversely affect:

- The quality of patient care;
- The delivery of and access to services;
- The health and safety of patients, employees and visitors to the Trust.
- The chance of something happening that will have an impact on the Trusts objectives.
- The ability of the Trust to meet contractual and financial targets.

The Trust recognises that not all risks can be eliminated, however action will be taken to minimise risks wherever reasonably practicable.

6.2 **OBJECTIVES**

Risk management is the term applied to a logical and systematic method of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating all risks, associated with any activity, objective, function or process. (see *appendix 9*) The risk evaluation process uses the terms consequence and likelihood to measure the severity of any risk. The Trust will use the Risk Management process and structure to minimise losses and maximise opportunities.

The Trust will manage to a reasonably practicable level all types of risk within the organisation, which include Environmental (*Health and Safety*), Clinical (*Patient treatment / care*), Financial and Corporate (*Trust wide*) risks (see *appendix 8*). As such the Trust recognises the need for all Staff within the organisation to be actively involved in the risk management, using the process to evaluate the risks involved within local and Trust objectives including the risks involved in failing to achieve those objectives.

The Trust affirms its commitment to providing, at all times, safe, places of work, systems of work, equipment, materials / substances for work, together with a safe and healthy working environment. This commitment extends to the Trust's employees, patients, visitors, and all others affected by the Trust's activities.

The Trust will keep all its work activities under review and will carry out regular risk assessments, internal and external audits so as to identify all matters likely to affect the safety of its employees, patients, visitors and others, as well as the effective and efficient running of organisational processes. Consequent upon such risk assessments / audits the Trust will put in place and implement such rules and procedures, preventive and protective measures, information and training for its employees and others, as are necessary to adequately control such risks.

6.3 **RISK MANAGEMENT STRUCTURE RESPONSABILITIES AND PROCESSES**

The Trust Board is responsible for reviewing the effectiveness of the internal controls – financial, organisational and clinical. The Board is required to produce statements of assurance that is doing its reasonable best to manage the Trust's affairs efficiently and effectively through the implementation of controls to manage risk. The Trust Risk Register is an important tool for recording all risks and the controls in place to remove or reduce those risks; it should be reviewed in line with the table (sec 6.5). The Board should also ensure this arrangement is reviewed annually or when procedural, legislative or best practice changes occur.

The Chief Executive has overall responsibility for Risk Management. Through the Management structure, the responsibility for ensuring controls are in place and agreed processes or procedures implemented and consistently adhered to are delegated to the appropriate directors. (*For more information see Appendixes 2 & 6*)

There are several **Groups / Committees and sub committees** who are charged with responsibility for risk management within their areas of competency and expertise. Their terms of reference detail their responsibilities and are included as appendixes of this policy.

These include

Clinical Governance Committee	(Appendix 10)
Risk Management Group	(Appendix 11)
Audit Committee	(Appendix 12)
Safety & Clinical Committee	(Appendix 13)

Risk management will be applied at all levels within the Trust as well as to specific projects, decisions or to manage specific risk areas. Two flow charts (*Appendixes 3 and 4*) show how the various committees are structured and linked together.

The lead Directors/Managers will be required to establish effective systems to:

- **Establish the context**
Establish the strategic, organisational and risk management context in which the rest of the process will take place. Define the activity. What are the goals and objectives?
- **Identify the risk**
Identify what, why and how risks can arise as the basis for further evaluation. (*What can happen, how can it happen?*)
- **Analysis of risks**
Determination of existing controls and analyse risk in terms of consequences and likelihood in the context of those controls. (*How could it happen, what would be the effect, how could the effect be removed or reduced*)
- **Evaluate risk**
Comparison of estimated levels of risk against the pre-established criteria (*Appendix 1*) thus enabling the identification of priorities. (*Compare the cost against the benefits*)
- **Treatment of risk**
Development and implementation of Action Plans.

Avoid	Do not proceed with the activity
Reduce	Reduce or control the likelihood and or the consequences
Transfer	Arrange for another party to share part of the risk (<i>contracts, partnerships, joint ventures</i>)
Accept	Some risks may be minimal and retention acceptable
- **Monitor and review**
To ensure the monitoring and review of risk and the performance of the risk management system.
Monitor risk impact, review the effectiveness of any actions, has the risk priority changed and escalate the risk in accordance with the table in **section 6.5**
- **Learning**
To have the capability to learn from service success as well as untoward incidents / service failures so avoiding similar incidents / failures in the future.
Who needs to know internal / external, who is affected.
- **Communicate and consult**
Communicate and consult with internal and external stakeholders as appropriate during the risk management process and concerning the process as a whole. Ensure that the Strategy is brought to the attention of all staff.
Ensure that risks within their areas of responsibility are communicated to staff.
Ensure that staff are aware of their personal responsibility and receive the appropriate information, training and instruction to enable them to work safely. These responsibilities extend to anyone affected by the organisations operations including sub-contractors, members of the public etc.
- **Policies and Procedures**
Directors and managers are responsible for preparing specific Directorate / Departmental policies and guidelines to ensure all risks are identified and controlled within their areas of responsibility in liaison with the appropriate advisors (Health & Safety, Infection Control, Moving & Handling etc)

All Staff will be responsible for:

- **Reporting of incidents**
All incidents / accidents including near misses should be reported through the appropriate channels (see *Risk Management Policy No 1*) Incidents will be graded using the risk evaluation matrix contained in this Policy. Appendix 1.

- **Complying with Policies and procedures**

Following all Trust and local policies and procedures and recommendations made within risk assessments covering their locations and working practices, also communicating when difficulties arise, so helping with the development / refinement of policies.

Strategy Implementation

The Risk Management Strategy will also be implemented through the further development, review and adherence by all staff to other Trust Policies and Procedures.

These include:

- The Chief Executive's General Statement on Health and Safety.
A brief outline of how the trust will meet the requirements of Health & Safety legislation and the roles and responsibilities of all staff
- Risk Management Policies (*Yellow Binder & Trust Intranet*)
- The Nursing and Therapy Policies (*Blue Binder & Trust Intranet*)
- Infection Control Policies and Protocols (*Red Binder & Trust Intranet*)

Together with other relevant policies, local procedures and protocols.

Objectives and Monitoring

To enable the Trust achieve its objectives / monitor its progress against national guidelines. It will be necessary to develop Key Indicators and benchmark against these indicators and with other similar organisations; the involvement of stakeholders in the development of these indicators should be encouraged a list of stakeholders are included in *appendix 10*.

The development of Key Indicators will be the responsibility of the various sub groups / committees that report to the Trust Board on both Clinical and Non Clinical matters (see *Appendix 3, 4 & 5*) and will be included in their Terms of Reference.

The terms of reference for the Risk Management group are contained in the Yellow Binder (*Trust Risk Management Arrangements*) Policy 24 together with the Safety & Clinical Committee Terms of Reference Policy 23.

A list of useful contacts including advice and expertise in the management of risk are included in *appendix 6*, along with a list of stakeholders *appendix 7* the involvement of stakeholders is vital to both the implementation and robustness of this Strategy.

6.4 STANDARDS FOR BETTER HEALTH

The strategy has the aim helping the Trust develop best practice in terms of risk management. Continuing to work towards meeting all the recommendations contained within all current and any new Standards for better Health will enhance the likelihood of achieving this aim. The actions required to achieve control are included in the Assurance Framework Action Plan, which will be presented to the Board for endorsement at regular intervals.

6.5 DEFINITION OF ACCEPTABLE AND UNACCEPTABLE RISK

The Trust will define its acceptable and unacceptable risk by scoring all risks using the Evaluation Table (*appendix 1*) and relating that score to the table below. The level of all risks will be scored as per the criteria contained within the Evaluation table by all staff when completing risk assessments. All incidents, Complaints and Litigations reported via the Incident Reporting System and risks within the Risk Register will also be scored using this risk rating.

After evaluation the following action will be taken.

Score	Acceptable / Unacceptable	Register Record	Report	Action
1 to 3	Acceptable	Record as low	New to be included in the report to responsible committee	Normal risks which can be managed locally by routine procedures
4 to 6	Unacceptable may be classed as acceptable after local controls are applied	Record as moderate	New to be included in Bi-monthly report to relevant Committee plus any specialist group with actions to date. To agree action plans and review in accordance with agreed time scale.	Investigated by the appropriate manager in conjunction with any specialist and action plan proposed for recommendation to relevant Committee
8 to 12	Unacceptable	Record as significant	New to be included in Bi-monthly report to the Risk Management Committee, plus any specialist group with actions to date. To agree action plans and review in accordance with agreed time scale.	Investigated by the appropriate manager in conjunction with any specialist group and action plan proposed for recommendation to Risk Manager for inclusion in report to appropriate Risk Management Committee Members and entered on the Risk Register.
15 to 25	Unacceptable	Record as high	Immediate notification to the Chief Executive and all Directors and the Board. To be included in report to Management Team, Clinical Governance Committee Risk Management Committee and the Board, plus any specialist group.	Immediate notification to the Chief Executive and all Directors. To agree action plans and review in accordance with agreed time scale entered on the Risk Register.

Other methods of reviewing Risk Management performance will include, ongoing improvement in compliance against the Standards for Better Health, progress in achieving RPST – CNST Levels. Board/Risk Management Committee review of the Risk Register and progress against action plans

6.6 **RISK REGISTER**

The Risk Register is a record of risks of all kinds that threaten the PCT's success in meeting its declared aims and objectives; the risks are prioritised using the Evaluation Table (*appendix.1*)

Risk Register will be developed at corporate and directorate level.

The Risk Manager will maintain the Risk Register. This will be populated by risks identified during the production of the Assurance Framework, CNST / RPST Assessments, Objective setting and Directorate Assessments /Action Plans (*in turn fed from Departmental Assessments / Action Plans*) together with risks identified during the normal risk assessment process that cannot be solved locally.

The Risk Register will form part of the regular reports to the Board, Management Team, Risk Management Committee and the Clinical Governance Committee.

APPENDIX 1

Risk Evaluation Table

CONSEQUENCES		PROBABILITY					
		Impossible	Rare	Unlikely	Moderate	Likely	Certain
		0	1	2	3	4	5
Negligible	0	0	0	0	0	0	0
Minor	1	0	1	2	3	4	5
Moderate	2	0	2	4	6	8	10
Serious	3	0	3	6	9	12	15
Major	4	0	4	8	12	16	20
Fatality/ies	5	0	5	10	15	20	25

Key:

0 No Risk	1 to 3 Low Risk	4 to 6 Moderate Risk	8 to 12 Significant Risk	15 to 25 High Risk
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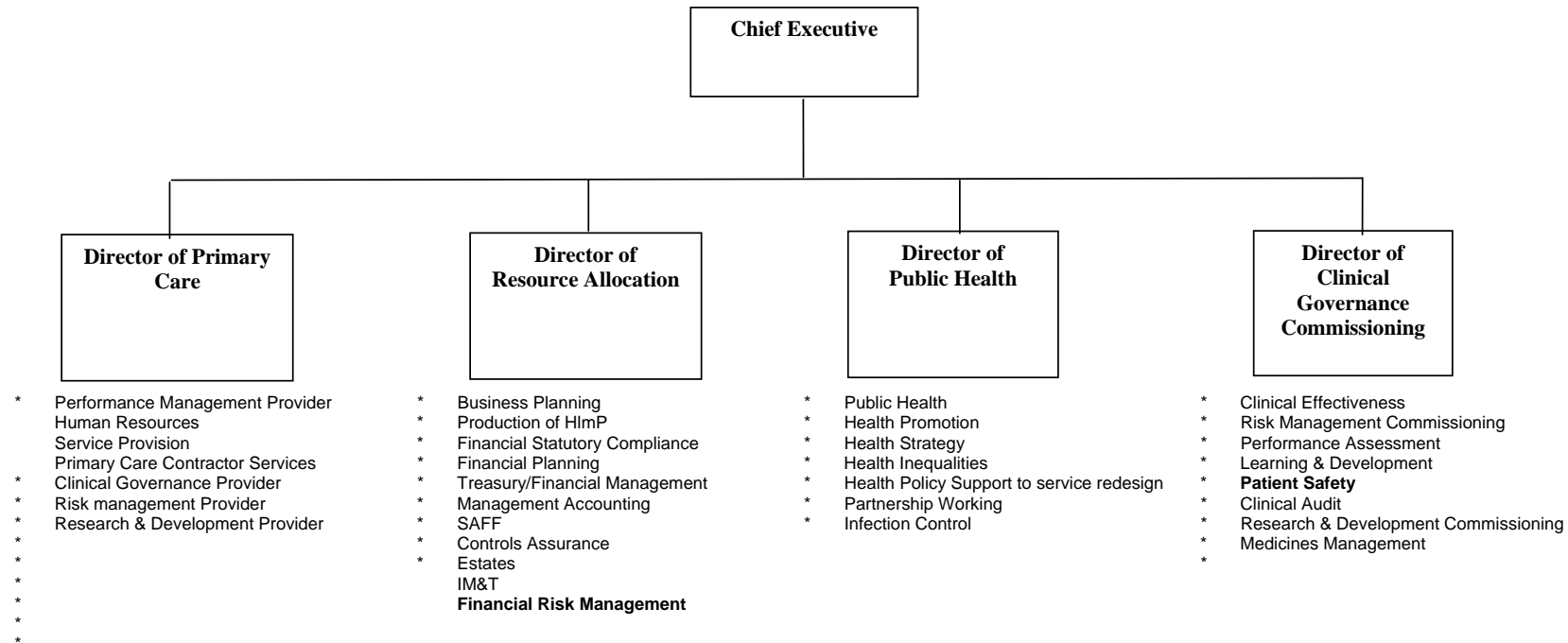
Negligible	No injuries to patients or staff. Financial loss no greater than £20. No legal obligations. No adverse publicity. No impact on service provision. Low possibility of complaint.
Minor	First aid treatment, no more than 3 days lost time. Financial loss less than £2,500, Minor legal obligations. Minor breach of working practices. Minor hazard. No adverse publicity. Minor impact on service provision. Verbal complaint dealt with at the point of complaint.
Moderate	Medical treatment required. No more than 5 days lost time, RIDDOR/MDA reportable. Minor environmental / infection control implications. Financial loss between £2,500 and £25,000. Moderate breach of working practices. Moderate hazard. Moderate loss of reputation. Moderate business interruption. Possible claim or written complaint.
Serious	Injuries requiring admittance to hospital for over 24hrs. No more than 7 days lost time. Moderate environmental / infection control implications. Financial loss between £25,000 & £50,000. Serious breach of working practices. Serious hazard. Serious loss of reputation. Serious business interruption. Probable claim or written complaint passed to director level for action.
Major	Excessive injuries requiring admittance to hospital for over 7 days, more than 7 days lost time. High environmental / infection control implications. Financial loss greater than £50,000. Major breach of working practices. Major loss of reputation. Major business interruption. Claim from patient or staff
Fatality/ies	Single or multiple death/s of any person/s

Examples of Excessive injury

- Any fracture
- Amputation
- Loss of sight (temporary or permanent)

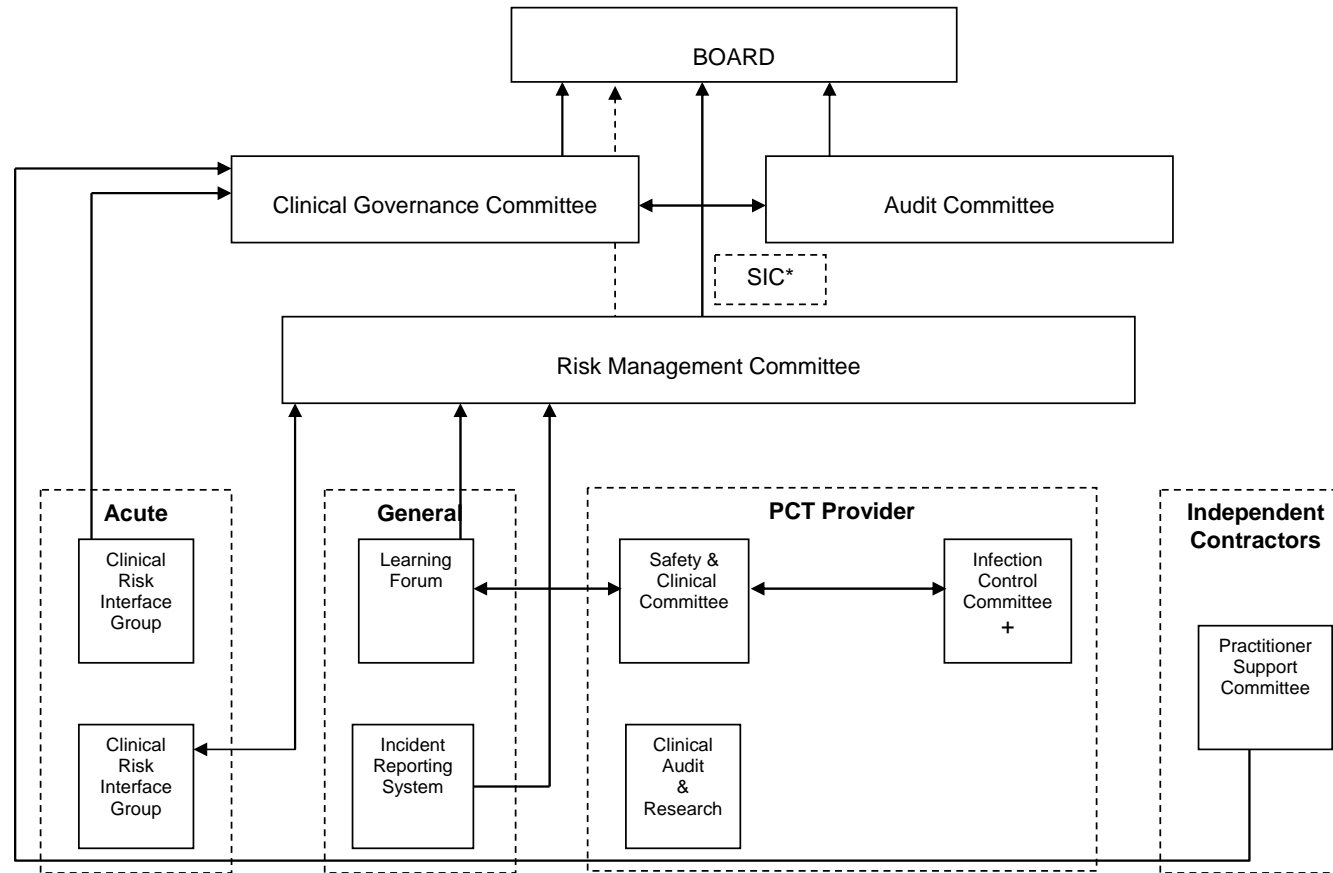
Adapted from As/NZS 4360:1999 – Risk Management

PCT MANAGEMENT TEAM



APPENDIX 3

PCT Governance Structures

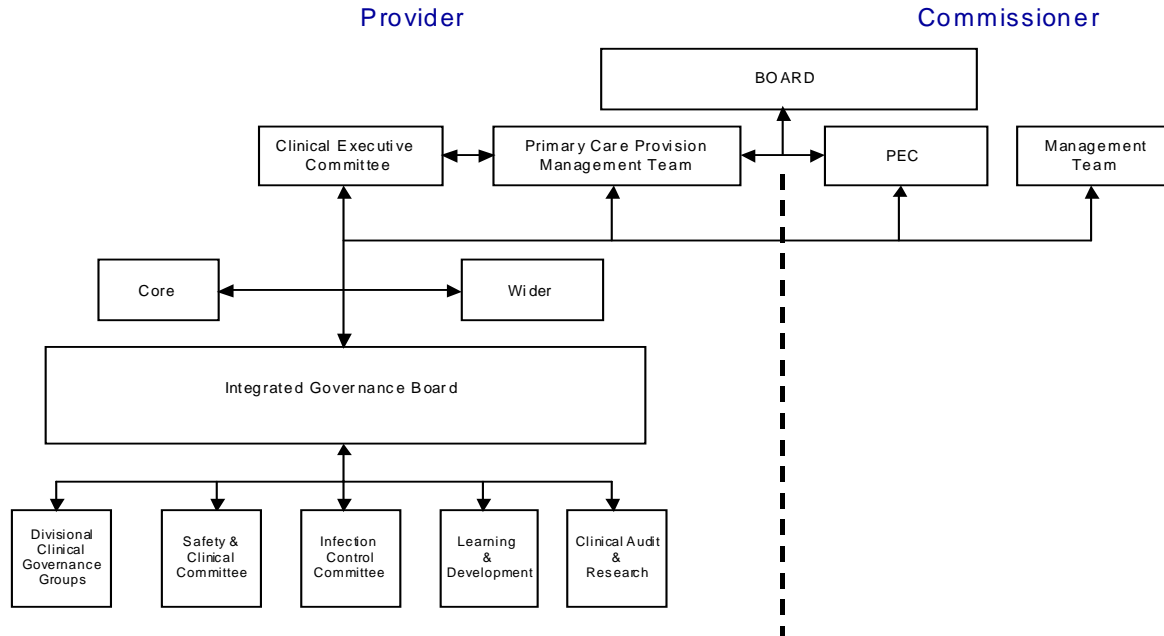


SIC* = Statement of Internal Control

+ = Also a wider Health Economy brief

Note This is a simplified diagram of relationships between governance bodies in the PCT. For the full scope and remit of these bodies, please refer to the individual terms of reference

Provider Arm Committee Structure



APPENDIX 5

USEFUL CONTACTS & RISK MANAGEMENT SPECIALISTS

1.1. Contacts within the Trust

The following people are the main points of contact within the Trust with respect to Risk Management. Department managers also have considerable knowledge regarding Risk Management and where appropriate should be contacted as a first point of call for Risk Management queries within your department.

Paul Phoenix Tel: 01204 462352
Risk Manager Great Lever Health Centre
The Risk Manager is responsible for the co-ordination of all risk management issues including risk assessments and provides advice on Health and Safety matters, protecting the safety of patients, staff and visitors. Co-ordinates and checks and collation of the accident/incident report forms and the risk register. Provides Health and Safety input to the corporate induction and other training as required.

Diane Sankey Tel: 01204 377006
Complaints Manager St Peters House
The Complaints Manager deals with all complaints and claims received by the Trust.

Anna Basford Tel: 01204 462320
Director of Service Provision Great Lever Health Centre
The Director of Service Provision has day-to-day responsibility for Health & Safety within the Trust.

Helen McKnight Tel: 01204 907010
Director of Clinical Governance St Peters House
The Director of Clinical Governance the day-to-day co-ordination of all Clinical Governance issues.

Ismail Hafeji Tel: 01204 907734
Interim Director of Finance St Peters House
The Director of Finance has day-to-day responsibility for financial decisions relating to the Trusts activities, including commissioning risks within the Trust.

Jan Hutchinson Tel: 01204 907725
Director of Public Health St Peters House
The Director of Public Health has day-to-day responsibility for the co-ordination of the Public Health, Health Promotion, Prevention and control of communicable disease, Health Strategy and Emergency Planning within the Trust

1.2 **Contacts outside the Trust**

Internal Audit

Tel: 01204 390447

For advice about internal processes which contribute to Standards for better health .

Willis UK Limited

Please contact the Risk Manager for contact details for Willis.

Willis are an insurance company who have been charged by the NHS Executive to assess all NHS Trusts throughout the country for compliance with the Risk Management Controls Assurance Standard (the core standard).

Clinical Risk Management Standards (CNST)

Please contact the Risk Manager for contact details for CNST.

Croner's (Health Service Risks – Management and Practice)

This is a regular publication containing a wealth of advice on best practice in risk management. Back copies are compiled into a file that is available from the Risk Manager.

APPENDIX 6

Related PCT Arrangements/Policies

Health & Safety Policy Statement

Incident/Accident reporting

Risk Assessment Policy

Whistle blowing Policy

Complaints Procedure

Violence and Aggression

Standing Financial Instructions

Standing Orders

GLOSSARY OF COMMON RISK MANAGEMENT TERMS

Adverse Event: Any event or circumstances leading to, unintended harm and/or suffering resulting in admission to hospital, prolonged hospital stay, significant disability at discharge or death.

Clinical Incident: A clinical incident is an occurrence resulting in an untoward outcome related to the direct care of a patient.

Clinical Risk: A clinical risk is a risk that could result in an untoward outcome related to the direct care of a patient.

Complaint: Action taken by a patient/client of a healthcare facility, or his or her agent, to communicate dissatisfaction or concern about any aspect of care/treatment or experience during a stay or visit or treatment.

Consequence: The outcome of an event, being a loss, injury, disadvantage or gain in respect of the physical, emotional, financial, social or credibility status of the individual or organisation.

Controls Assurance: A process designed to provide evidence that the NHS in total and its constituent parts is doing its reasonable best to manage, direct and control itself so as to protect itself, its employees, patients and stakeholders' safety and interests against all kind of risks.

Cost: Activities, both direct, and indirect, which result in a negative outcome or impact for an individual or the organisation - cost includes money, time, labour, disruption, goodwill, and intangible losses.

Event: Incident or situation occurring in a particular place during a particular interval of time.

Frequency: A measure of the rate of occurrence of an event expressed as the number of occurrences of an event in a given time.

Financial Risk: A risk which if not controlled could have an adverse effect on the Trust / Directorate budget/s. There are three forms of financial function involved in the transfer or reduction of risk, they are carefully controlled so to minimise the amount of funds that are diverted away from direct patient care.

Deleted:

Deleted:

Hazard: A source of potential harm or a situation with the potential to cause loss.

Incident Reporting and Investigation: A formal structured process, approach to enable the occurrence of incidents to be reported, recorded and the root cause of reported incidents identified, in order to manage risk exposure and identify required corrective actions.

Likelihood: A qualitative measure/description of probability or frequency.

Loss: Any negative consequence, financial or otherwise.

Monitor: To check, supervise, observe critically or record the progress of an activity, action or system on a regular basis in order to identify change.

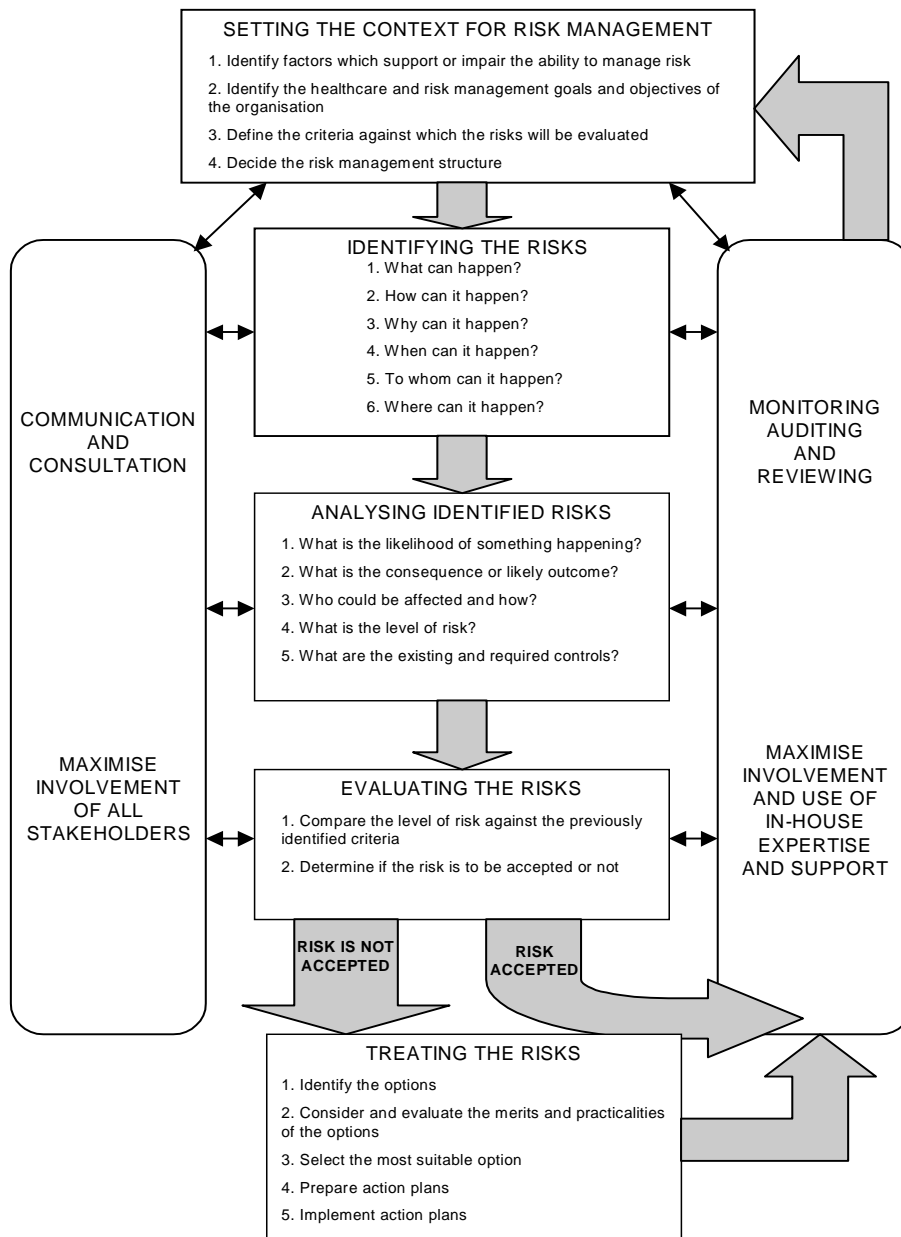
Near Miss: A situation in which an event or omission, or a sequence of events or omissions, fails to develop further, whether or not as the result of compensating action, thus preventing harm to patients, staff or the organisation.

System Failure: A non-conformance with, malfunction of or deviation from a defined management system. A system failure may also be defined as inadequate performance, non-participation in or non-application of a defined management system or process.

Untoward Incident: is an incident that could not be classed as accidental, examples of which could be an assault or an act of vandalism. (*For serious untoward incidents see sec 1.4.1 of Trust Arrangement No 1 Incident reporting*).



Risk Management Process



Adapted from As/NZS 4360:1999 – Risk Management

STAKEHOLDERS

Patients, visitors and the public.
Staff
Trust departments, both service delivery and support services
Royal Bolton Hospital
GPs
Pharmacists
Dentists
Opticians
Local community groups, as appropriate
Bolton Metro, particularly Social Services
Local Counsellors
Strategic Health Authority
North West NHS Regional Office
NHS Litigation Authority
Solicitors, both Fieldings Porter and Hempsons
Health and Safety Executive
Medicines and Healthcare products regulatory Agency.
Clinical Negligence Scheme for Trusts
Risk Pooling Scheme for Trusts

CLINICAL GOVERNANCE COMMITTEE

TERMS OF REFERENCE

1. Purpose

The Clinical Governance Committee is the formal mechanism by which the PCT discharges its responsibilities for clinical quality and sets the strategic direction for clinical governance within Bolton Primary Care Trust.

1. Accountability

The Clinical Governance Committee will report directly to the PCT Board in accordance with HSC 99/65.

The need for a reporting mechanism to the Professional Executive Committee (PEC) and PCT Management Team is acknowledged. This will be achieved by two members of the PEC sitting on the Clinical Governance Committee (one as chair) and the Director of Clinical Governance reporting to the Management Team.

2. Membership

Stephen Liversedge - PEC Chair
Colin Mercer - PEC GP
Bob Hunt - NE LHG Clinical Governance Lead
Vacant - West LHG Clinical Governance Lead (John Tabor?)
Vacant - SE LHG Clinical Governance Lead
Claire Fish/Margaret Ranyard - Social Services Representative
Rose Naylor - RBH Representative
Pam Senior - PCT Chair/Non Exec (Lay Member)
Alan Cowie - Representing Provider - Clinical Governance Leads Group
Jan Hutchinson - Director of Public Health
Helen McKnight - Director of Clinical Governance (also representing Clinical Care Group, Education and Training Strategy Group and Risk Management Group)

Other groups/colleagues to be co-opted when agenda items require it

- Human Resources
- Information Technology
- Bolton, Salford, Trafford Mental Health Partnership
- Research & Development

Colleagues from GMAS and Internal Audit are welcome as observers

3. Duties of the Committee

To foster a culture of Clinical Governance across the organisation that supports the delivery of good quality care.

To ensure that structures and processes are in place between the Royal Bolton Hospital, Social Services and the PCT as pathways of care across health and social care are established to enable effective clinical services to be delivered.

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Formulating the policy and the strategy for the development and maintenance of Clinical Governance (indicating clear lines of responsibility and accountability for the overall quality of clinical care) for approval (as necessary) by the PEC, Management Team and Board of the PCT.

Approving the production of strategies and action plans (for a comprehensive programme of quality improvement activities) from sub committees and those responsible for the implementation of the strategy. Sub committees include:

- Practitioner Support Committee
- Risk Management Group
- Learning & Development Strategy Group
- Clinical Care Group
- Research & Development Strategy Group
- Local Health Group or Professional/Service Clinical Governance Groups

To ensure that the organisations internal strategies support the delivery of high quality services e.g.

- Workforce development plans
- Recruitment and retention plans
- Learning and development including appraisal and CPD
- Knowledge management, data and information
- Data protection

To ensure that clinical audit underpins the continual development of clinical care via an effective organisational approach to audit.

To ensure that the organisation and its partners learn from adverse events and that information - reports are received and reviewed on a regular basis from complaints, clinical sub group, risk management etc, and these are collated and used to drive learning and change.

To ensure the effective involvement of patients/service users within Clinical Governance and quality improvement programmes.

Ensuring that there are adequate systems, key indicators in place to support and monitor the performance and effectiveness of clinical governance activity within the PCT.

Identifying the resources required for the effective functioning of clinical governance activities within the PCT.

Report regularly to the PCT Board and the PEC on the quality of clinical care, which the PCT provides, commissions, or for which it is otherwise responsible. (See 8.1 for distribution of minutes)

4. Meeting Frequency

The Committee will meet bi-monthly

5. Quorum

At least one-third of the Committee must be present for the meeting to be quorate

6. Reporting Mechanisms

The minutes of the meeting shall be a standing agenda item for subsequent Clinical Governance Committee meeting.

The Committee will provide an annual clinical governance report to the PCT Board.

The Committee will disseminate information relating to its business to all clinicians within the PCT / local health economy.

The Committee will receive reports from the Clinical Governance Sub-committees.

7. Distribution of Minutes

Minutes of the Group will be forwarded to, PCT Board, and the PEC.

8. Review

The membership of this Group and the terms of reference will be reviewed every two years.

APPENDIX 11

The Terms of reference below are part of Risk Management Policy No 24

TERMS OF REFERENCE FOR THE TRUST RISK MANAGEMENT COMMITTEE

Ensure the co-ordination and prioritisation of all risk management issues.

Carry out an annual review of all Trust Policies / Arrangements relating to risk management.

- Incident reporting
- Risk Management Strategy
- Claims Complaints and Litigation
- PALS

Ensure that appropriate information, education and training on risk management and other issues is provided for staff at all levels within the PCT including PEC and Board Members Act as Learning Forum to enhance Staff, Patient and Public Safety and the improvement of service provision and to influence service redesign.

Monitor and review the PCT risk register, ensuring that risks are managed and controlled appropriately throughout the trust.

To oversee the production and implementation of Trust and Directorate action plans.

Monitor progress against compliance with standards set by outside agencies.

- CNST/RPST
- Healthcare Commission

Identify how changes in Trust objectives will effect the management of risk and help to develop and monitor any control measures.

Develop and monitor progress against locally developed key indicators. (See *appendix 1*)

Review the PCT's audit arrangements including

- Internal audit
- Clinical audit
- Health and Safety reviews.

Receive reports and copies of the minutes from Sub Committees

- Health Safety & Clinical Committee
- Infection Control Committee.

The Committee needs arrangements for evaluating the assurances it receives.

- The Committee is responsibility for evaluating assurances, and the importance it has for the completion of the Statement of Internal Control (SIC).
- The Committee should be sufficiently knowledgeable in the areas reviewed, to understand the implications of the assurances given.
- There should be an element of independence in the process for evaluating the assurances received, so that the outputs from assurance work are not reported only to those responsible for managing the system of control. This may involve non-executive directors in the process as useful members of the Committee.
- There should be an audit trail so that the link between the assurers reports, and the value placed on them for the SIC, should be clear.

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- There should be regular reporting to the Board on the progress in collecting and evaluating assurances required by the Assurance Framework.
- The assurance process itself should be subject to independent audit, and reported to the Audit Committee.

The Board should however retain overall responsibility for the process, and to assist this, should require regular updates on the extent to which assurances are being received, and any significant concerns which may impact on the SIC at the end of the year. As agreed at the April 04 Board meeting, this will be for all risks scored in excess of 15 on the risk evaluation table. The risk management committee can report directly to the Board and Audit Committee to ensure that this happens efficiently.

MEMBERSHIP OF TRUST RISK MANAGEMENT COMMITTEE

Non Executive Director (chair).
Director of Clinical Governance.
Director of Service Provision.
Director of Resource Allocation.
Director of Public Health.
Assistant director of Nursing.
Practice Manager
Risk Manager.
Complaints Manager
Senior PALs Officer

A Person from Internal Audit is invited as an observer to all meetings.

If named representatives are unable to attend then a deputy should be sent in their place.

Co-opted Members

The Committee may request the attendance of any person not normally a member to provide information on a specific topic.

FREQUENCY AND MANAGEMENT ARRANGEMENTS FOR MEETINGS

a) Frequency

Meetings will be held monthly - dates, times and venues to be arranged each January.

b) Quorum

A quorum shall be three members however for decisions on important issues when a quorum cannot be achieved agreement on an issue will be sought and accepted in writing.

d) Secretarial Support

Will be provided by the Risk Manager.

f) Records of attendance

The names of the members attending the meeting of the Committee will be recorded in the minutes.

g) Minutes and Agendas

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Minutes of the Committee meetings shall be drawn up by a person nominated by the Risk Manager. Members of the Committee including observers and co-opted members will be provided with copies within 2 weeks of the meeting. Copies will be distributed to Committee via personal email or internal mail a record of distribution and receipt will be kept for audit purposes

The Agenda and associated papers will be distributed at least one week in advance of meetings, items for inclusion on the agenda should be sent to the Risk Manager at least two weeks before the date of the next meeting.

Key Indicators

	<u>Subject</u>	<u>Action</u>	<u>Report to</u>
1	Accident Incidents	Track and trend incident and accidents monthly.	Board. Relevant sub Committees
2	Training	Compare training returns against targets trust objectives / needs analysis	Board. Relevant sub Committees Training and HR
3	Claims Complaints and PALS queries	Track and trend monthly figures.	Board. Relevant sub Committees

APPENDIX 12

Audit Committee

Terms of Reference

Constitution	The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (The Committee).
Membership	The Committee shall be appointed by the Board from amongst the Non Executive Directors of the Trust and shall consist of not less than 3 members. A quorum shall be 2 members.
Attendance	The Director of Resource Allocation, the Head of Internal Audit and a representative from the External Auditors shall normally attend meetings. However, at least once a year the Committee may wish to meet with the External and Internal Auditors without any executive Board director present.
Frequency	Meetings shall be held not less than three times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.
Authority	<p>The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.</p> <p>The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.</p>
Duties	<p>The duties of the Committee can be categorised as follows:</p> <p style="text-align: center;">Internal Control and Risk Management</p> <ul style="list-style-type: none"> ❖ The Committee shall review the establishment and maintenance of an effective system of internal control and risk management. <p>In particular, the Committee will review the adequacy of :</p> <ul style="list-style-type: none"> ❖ all risk and control related disclosure statements, together with any accompanying Head of Internal Audit statement, prior to endorsement by the Board; ❖ the structures, processes and responsibilities for identifying and managing key risks facing the organisation; ❖ the policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements as set out in the Controls Assurance Standards and other relevant guidance; ❖ the operational effectiveness of policies and procedures; ❖ the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Directorate of Counter Fraud Services.

	<p style="text-align: center;">Internal Audit</p> <ul style="list-style-type: none"> ❖ to consider the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal; ❖ to review the internal audit programme, consider the major findings of internal audit investigations (and management's response) and ensure coordination between the Internal and External Auditors; ❖ to ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation. <p style="text-align: center;">External Audit</p> <ul style="list-style-type: none"> ❖ consider the appointment of the External Auditor, as far as the Audit Commission's rules permit; ❖ discuss with the External Auditor, before the audit commences, the nature and scope of the audit and ensure coordination, as appropriate, with other External Auditors in the local health economy; ❖ review External Audit reports, including value for money reports and management letters, together with the management response. <p style="text-align: center;">Financial Reporting</p> <p>Review the annual financial statements before submission to the Board, focusing particularly on :</p> <ul style="list-style-type: none"> ❖ changes in, and compliance with, accounting policies and practices; ❖ major judgemental areas; and ❖ significant adjustments resulting from the audit.
Reporting	The minutes of Audit Committee meetings shall be formally recorded and submitted to the Board

APPENDIX 13

The Terms of reference below are part of Risk Management Policy No 23

TERMS OF REFERENCE FOR THE TRUST SAFETY & CLINICAL COMMITTEE

- a) The study of accidents and notifiable diseases, statistics and trends, so that reports can be made to management on unsafe, unhealthy conditions and practices, together with recommendations for corrective action.
- b) Examination of safety inspection reports on a similar basis.
- c) Consideration of reports and recommendations received from the Health Services Advisory Committee, the Health and Safety Executive or the Local Authority.
- d) Consideration of reports which safety representatives may wish to submit.
- e) Assistance in the development and review of safety arrangements, procedures and safe systems of work.
- f) A watch on the effectiveness of the safety content of employee training.
- g) Help with the development and monitoring of Local Key Indicators (*Appendix 1*)
- h) A watch on the adequacy of safety and health communication and publicity in the workplace.
- i) The provision of a link with the appropriate inspectorates of the enforcing authorities.
- j) To review the effectiveness of the response to Safety Action Bulletins and Hazard Notices received from the Department of Health.
- k) In certain instances the committee may consider it useful to carry out an inspection or audit of a work place or activity by the committee itself.
- l) The provision of a link with the Control of Infection Committee, Occupational Health Department etc.

23.3 MEMBERSHIP OF THE COMMITTEE

- a) **Management Representatives**
Director of Service Provision
Estates Officer
Representative from Children's Services
Representative from Dental Services
Two representatives from Allied Professions (Heads of Service 1 x Physiotherapy
1 x Podiatry)
- b) **Ex Officio**
Occupational Health Representative, Infection Control Representative, Human Resources Representative, Training Representative and the Risk Manager.
- c) **Staff Side Representatives**
One representative from each of the recognised Trade Unions, Professional Organisations and Employee representatives.
- d) **Co-opted Members**
The management or staff side may request the attendance of any person not normally a member to provide information on a specific topic.

23.4 FREQUENCY, DURATION AND MANAGEMENT ARRANGEMENTS FOR MEETINGS

- c) **Frequency**
Meetings will be held 2 monthly - dates, times and venues to be arranged each January for that year. This information should allow managers to make the necessary arrangements to enable representatives to attend. These dates will be posted on the Trust Intranet in the Health and Safety area.
- d) **Quorum**
A quorum shall be four members from each side, excluding ex officio members.
- c) **Officers**
There shall be elected annually a Chairman and Vice Chairman who may be from the Management and Staff side on a rotating basis.
- d) **Secretarial Support**
Will be provided by the Risk Management Department.
- e) **Attendance of substitutes**
If a member of the Committee is unable to attend, then a named substitute should be nominated.
- f) **Records of attendance**
The names of the members attending the meeting of the Committee shall be recorded in the minutes and every member attending shall sign the attendance sheet provided for that purpose.
- g) **Minutes and Agendas**
A person nominated by the Risk Manager will draw up minutes of the Committee meetings. Members of the Committee shall be provided with copies within 2 weeks of the meeting via email. Copies for information will be distributed to Risk Management Committee members via personal email. All other staff via staff notice boards in Trust premises and posted on the Trust Intranet. The Agenda and associated papers will be distributed at least one week in advance of meetings, items for inclusion should be sent to the Risk Manager at least two weeks before the date of the next meeting.

Key Indicators

	<u>Subject</u>	<u>Action</u>	<u>Report to</u>
1	Accident / Incidents	Track and Trend incident and accident figures.	The Safety & Clinical Committee. Risk Management Group Staff Groups
2	Training	To monitor attendance and report	The Safety & Clinical Committee.
3	Claims / Complaints	Track and Trend Quarterly figures.	Risk Management Group
4	Infection Control	To monitor infection rates in all areas where PCT staff work	The Safety & Clinical Committee.
5	Occupational Health	To monitor attendance and report	The Safety & Clinical Committee.
6	Moving & Handling	Track and Trend incident and accident figures	The Safety & Clinical Committee.